Final Evaluation and Sustainability Assessment

Child Survival V Guayape

World Relief Corporation/Honduras

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Abbreviations and Acronyms

ACPH	-	Asociación Cultural Popular de Honduras
ADRA	-	Adventist Development and Relief Association
ASHONPLAFA	-	Asociación Hondureña de Planificacion Familiar
ARI	-	Acute respiratory infections
BCG	-	Bacillus of Calmette-Guerin
CHW	-	Community health worker
CS	-	Child survival
CS-G	-	Child Survival-Guayape Project
DIP	-	Detailed Implementation Plan
DPT	-	Diphtheria, pertussis, tetanus
EPI	-	Expanded Program on Immunization
FHA/PVC	-	Bureau for Food and Humanitarian Assistance, Office of Private and Voluntary Cooperation
KPC	-	Knowledge, practice, and coverage
MSP	-	Ministry of Public Health
NGO	-	Non-Governmental Organization
ORS	-	Oral rehydration solution/salts
ORT	-	Oral rehydration therapy
PAHO	-	Pan American Health Organization
PREDISAN	-	Predicación and Sanidad
PVO	-	Private Voluntary Organization
TBA	-	Traditional birth attendant
TT	-	Tetanus toxoid
USAID	-	United States Agency for International Development
WRC	-	World Relief Corporation
WRH	-	World Relief Honduras

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Acknowledgement

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Final Evaluation and Sustainability Assessment of Guayape Child Survival V Project

I. Executive Summary

With funding from the United States Agency for International Development (USAID), World Relief Corporation has been managing since September 1, 1989, the Guayape-Honduras Child Survival V Project in communities within two departments, both northeast of Tegucigalpa: Francisco Morazan and Olancho. The project is scheduled to end August 31, 1994.

From July 4 to July 15, an evaluation team conducted 151 in-depth, qualitative interviews with persons who had influenced the design, implementation and evaluation of the project and with those who would influence its sustainability.

Above all, training, health education, and improving relations between the community and the MSP health centers were found to be the most useful in terms of empowering the communities to better meet their basic health needs with a package of effective interventions likely to be sustainable.

A total of 399 health guardians had been trained during the project, 85 percent of whom were still working at project end. The retention rate for health guardians was outstanding in comparison with similar child survival projects worldwide. Of 118 health committees organized during the project, 75 (64%) were actively working to support the health guardians at the end of the project.

The success of the guardians in educating the community can best be seen by examining the child survival indicators. Most of the objectives proposed in the Detailed Implementation Plan (DIP) were achieved or nearly achieved. At the end of the project, 88 percent of children 12-23 months were completely immunized; 74 percent of children 0-23 months in the project communities were being weighed monthly; almost all women were breastfeeding, 68 percent exclusively for the first four months; the majority of post-partum women 15-45 and children 6-59 months had received Vitamin A; 80 percent had received prenatal care; 32 percent were using family planning; and 78 percent of mothers 15-45 could identify and facilitate the treatment of pneumonia.

The project was less successful in terms of ORT use. Only 58 percent of mothers were using it although 75 percent knew how. Nonetheless, MSP nurses reported that cases of dehydration presented at health centers had greatly decreased.

The proportion of mothers instructed in breastfeeding, weaning, and nutrition was approximately two-thirds the objective.

Progress toward child survival objectives can be seen as contributing to sustainability at the household level. Mothers will continue practicing what they have been taught under the project to the extent that the interventions become institutionalized and reinforced by MSP personnel, health guardians continuing under the auspices of the MSP, neighbors, health committee members, teachers, and school children.

The evaluation team found that WRH had been very successful in promoting institutional sustainability by closely coordinating the project with the MSP, especially at the regional and local levels, from the beginning of the project, and by coordinating some activities with private voluntary organizations (PVOs).
By far, the most important linkage is that between health guardians and MSP auxiliary nurses at the local level. The support being given to each guardian by the auxiliary nurse, and vice versa, is an important key to the sustainability of the project. In August/September, 1993, responsibility for training and supervising the guardians was officially transferred from WRH to the MSP. Since December, 1993, the HIS developed under the project has been located within the local MSP health centers, and guardians now report data directly to the center.

The MSP, however, may not be able to sustain training and field supervision at the same level as that which has been provided by WRH. WRH is, therefore, entering in dialogue with private organizations, along with the MSP, to explore ways to support former WRH activities.

In addition to training and supervising guardians and helping to organize health committees, training was also given to teachers to enable them to successfully deliver lessons on children survival within the regular primary school curriculum. Teachers interviewed have indicated that they will be able to continue health lessons with technical support from the MSP when needed. A total of 590 traditional birth attendants (TBAs) also received training, many of whom will continue to practice their new skills.

Following are the key recommendations of the evaluation team for sustainability:

- The MSP, at both regional and local levels, should ensure that its health personal at the local level, especially auxiliary nurses, are involved in the health activities carried out by health guardians by directing, supervising, and motivating them;

- The MSP should include in its budget a line item for expenses for supervision and training of health guardians or use funds from the A.I.D./Honduras Regional Rotating Fund for this purpose;

- Non-Governmental Organizations (NGOs) should strengthen their coordination with the MSP at all levels of their projects;

- NGOs should not give cash payment to health guardians so that the community may continue working without assistance from the NGO in the future; and,

- NGOs should use community resources in training health guardians.

The key lessons learned for sustainability are:

1. Unless each aspect of the program during all the stages of the Project (the proposal, the health messages, the structures, supervision policies, the health information system, reference system, costs) are developed together with the MSP, there will be no hope of sustainability.

2. In order to have a close relationship with the MSP there should be a strategy (which is effective for the MSP personnel) for motivating and facilitating joint labor and the training of volunteers.

3. The local health committees, which at the beginning function as support groups for the health guardians, are very important in order to ensure community participation, but their function should be carefully defined in order for them to be effective.

4. It is good to emphasize education of the community by means of community volunteers, but it is not effective to have all the work depend exclusively on one type of volunteer, for example, health guardians only. The community should be helped to integrate actions with networks of responsible individuals in the community.

5. In a context where material incentives are not possible, the health volunteer can work effectively with nonmaterial incentives, such as the prestige and knowledge acquired and the sense of importance which the work has for the community, something which is more sustainable.

6. The careful recruitment of volunteers and training on the characteristics and functions of the health volunteer are important since they greatly influence whether or not he/she continues.

II. Introduction and Background

With funding from the United States A.I.D., World Relief Corporation has been managing since September 1, 1989, the Guayape-Honduras Child Survival V Project in communities within two departments, both northeast of Tegucigalpa: Francisco Morazan and Olancho. The project is scheduled to end August 31, 1994.

From July 4 to July 15, an evaluation team comprised of project staff members, an external consultant, and a representative from the Ministries of Christian Services, an NGO, began the final evaluation of the project following guidelines of the A.I.D. Bureau for Food and Humanitarian Assistance, Office of Private and Voluntary Cooperation (FHA/PVC). Evaluation findings are reported here according to the guidelines.

III. Summary of Project Accomplishments and Lessons Learned

A. Project Accomplishments

A1. Objectives and Accomplishments

Following are the indicators and objectives of the Guayape Child Survival Project, as outlined in the DIP. For most indicators, baseline data collected in Year One and/or Two of the project are displayed along with end-of-project data collected in Year 5. Objectives, as reported in the DIP, are reported in the last column. In some cases, the objective was revised upward after baseline studies were conducted.

Unless otherwise noted, the data from Year 1 was collected in a large-scale survey in which 803 family heads, representing 10 percent of the target population, were interviewed. Data from Year 2 was collected in a 30-cluster Knowledge, Practice, and Coverage (KPC) survey. Two sources of data are reported as an indication of the end-of-project status: a 1994 30-cluster KPC survey and the routine data collection system of the health guardians working under the project. The KPC survey was conducted in clusters randomly selected from throughout the project departments of Olancho and Francisco Morazan, whereas information collected by the health guardians pertains only to communities in which they worked. Therefore, measures of indicators reported by the information system would be expected to be the same or somewhat higher than those reported by the survey. This was the case for all but one indicator, i.e. mothers trained in nutrition.

World Relief of Honduras
Guayape Child Survival Project
Objectives and Goals, Project Years 1-5, 1989-1994

	Objectives	Investigations			HIS Year 5	DIP Final Goal
		Y 1	Y 2	Y 5		
1	Children 12-23 months completely immunized	87%	84%	88%	NA	80%
2	Children 24-59 months completely immunized	92%	NA	NA	93%	90%
3	Women 15-45 vaccinated with two doses Tetanus Toxoid	55%	NA	73%	NA	85%
4	Women able to prepare and administer ORT/ORS	NA	73%	NA	75%	80%
5	Women evidencing regular use of ORT/ORS during diarrheal episodes in their children	16%	45%	44%	58%	70%
6	Children 0-23 months weighed monthly	NA	32%	34%	74%	80%
7	Children 24-59 months weighed once every three months	NA	NA	NA	74%	70%
8	Mothers who have breastfed their children 0-23 months	91%	98%	98%	98%	90%
9	Mothers who exclusively breastfeed children until four month of age	29%	NA	55%	68%	50%
10	Mothers instructed in breastfeeding, weaning, nutrition	NA	NA	NA	57%	90%
11	Children 6-23 or 6-59 months (see note) receiving Vitamin A	20%	NA	59%	68%	60%
12	Mothers post-partum receiving Vitamin A	NA	NA	NA	76%	80%
13	Women utilizing modern birth spacing methods	NA	19%	32%	NA	30%
14	Women receiving prenatal care	67%	73%	80%	NA	70%
15	Women 15-45 instructed in prevention of death from pneumonia	NA	31%	46%	51%	50%
16	Women 15-45 who can identify and facilitate treatment of pneumonia in children 0-59 months	NA	46%	54%	78%	30%
17	# Health Guardians trained for inclusion into MSP	60	126	399	NA	343
18	# Local Health Committees organized	NA	51	118	NA	120

NA = Not available.

Notes by indicator:

1 & 2 For Year 1, information was collected for fully-immunized children 12-59 months. Beginning in Year 2, information pertains to children 12-23 months.

11 The 59 percent of children given Vitamin A in the survey for Year 5 pertains to the age group 6-23 months. The 68 percent of children who received Vitamin A as tracked in the project information system refers to children 6-59 months.

13 The Year 5 figure modern contraceptive prevalence was based on all non-pregnant women.

15 & 16. In Year 2 of the project, objectives and indicators for "acute respiratory infection (ARI)" were changed to "pneumonia."

17 & 18. Information is taken from the routine data collection system.

Data must be interpreted cautiously for several indicators due to changes in project strategy or external circumstances. In some cases, indicators, definitions of indicators, and methods of measuring them also changed somewhat during the project to reflect new technical knowledge, a change in Ministry of Public Health (MSP) policy, or a change in A.I.D. monitoring requirements.

Immunization. The table shows that the proportion of children fully-immunized remained stable through the life of the project at 87-88 percent, approximately the objective of 90 percent. The initial baseline figure, however, includes children 12-59 months rather than 12-23 months, as reported in later project years. The increase, therefore, was probably somewhat greater. Although quantitative data regarding the month in which children received vaccinations have not been analyzed, MSP nurses have suggested that a greater percentage of those fully-immunized being brought to the health centers in a more timely fashion rather than being exposed to disease by being brought in later than recommended.

The proportion of women receiving two doses of tetanus toxoid (TT) increased from a baseline of 55 percent to 73 percent, as measured on a 30-cluster survey at project-end, compared to an objective of 80 percent. As the wide confidence interval for cluster surveys (+ or - 10 percent) includes the objective, whether or not the goal was reached cannot be definitively determined.

Management of Diarrheal Diseases. Although no data are available on the number of mothers who had been instructed in oral rehydration therapy (ORT) at the initiation of the project, the first KPC survey indicated that 73 percent of the target population had been trained by Year 2. The percentage increased slightly to 75 percent by month 10 of the 5th project year, nearly reaching the 80 percent objective.

The proportion of the population who report using ORT, however, is significantly less than the proportion who were trained. Beginning with 16 percent reporting its use, about 44 percent were reporting ORT use in each of the KPC surveys conducted in Years 2 and 5 of the project. A somewhat higher 58 percent was reported by guardians in the World Relief Honduras (WRH) project areas in Year 5, still under the 70 percent objective for this indicator, however.

The nearly two-fold increase from Year 1 to Year 2 in ORT use can be attributed somewhat to a cholera epidemic in Year 2 which greatly facilitated acceptance of the method. A change in strategy probably contributed to an end-of-project measure which did not meet the objective. After the Mid-Term Evaluation, the message for ORT use was changed to recommend that ORT be used for severe or dehydration diarrhea cases but that routine cases of diarrhea could be treated by increasing the intake of liquids normally given.

In addition, a nurse supervisor in the MSP mentioned that before the work of the guardians, mothers were often using oral rehydration solution (ORS), or Litrosol, as a medicine, giving very small amounts rather than using it properly for rehydration. After health education efforts on the part of the guardians, she saw much more appropriate use of ORS.

MSP nurse supervisors, nurses, auxiliary nurses, and one doctor have noted that cases of severe diarrhea and ARI have diminished due to the health education provided by guardians. Mothers are using Litrosol (ORS), and children are brought to the health center only when indicated.

Nutritional Improvement. When looking at the number of children 0-23 months weighed monthly (Indicator No. 6), it can be seen that only 32 percent and 34 percent, respectively, of the children whose mothers were interviewed in the KPC surveys in Years 2 and 5 of the project were participating in a growth monitoring program. These interviews were conducted throughout the project area in communities where WRH-trained guardians were working as well as communities where WRH guardians were not working. In comparison, 74 percent of those in the project communities were being weighed regularly, almost reaching the five-year objective of 80 percent. The proportion of children 24-59 months weighed every three months surpassed the objective of 70 percent.

The proportion of mothers who had ever breastfed their children was very high throughout the project. In the initial baseline survey, 91 percent indicated that they had breastfed their child 0-23 months, already surpassing the 90 percent objective. Although the proportion increased to 98 percent from Year 2 to Year 5 of the project, the evaluation team concluded that the project interventions had little effect on breastfeeding per se. The data do show an effect of the project interventions on exclusive breastfeeding until four months of age, however. Beginning with 29 percent of the population practicing exclusive breastfeeding at baseline, the proportion rose to 55 percent in the KPC survey and 68

percent in the project communities, possibly reaching or surpassing the 50 percent objective. This gain occurred even though the achievement in training fell somewhat short, reaching 57 percent of the project population with instruction in breastfeeding, weaning, and nutrition compared to a significantly higher objective of 90 percent of the target population in project communities.

Beginning with a baseline of 20 percent of children 6-59 months receiving Vitamin A, 59 percent were reported in the final KPC survey and 68 percent in the information system to have received Vitamin A from the health guardians, equaling or surpassing the objective of 60 percent. Three-fourths (76%) of the mothers also received Vitamin A post-partum, approaching the 80 percent objective.

Reproductive Health. Although the percentage of women receiving prenatal care at the time of the baseline survey nearly approached the objective (67% vs. 70%), some improvement was still shown. The proportion had increased to 73 percent at the time of the KPC survey in Year 2 and to 80 percent in Year 5.

The end-of-project objective for child spacing was 30 percent, and it was nearly reached. In the KPC survey in Year 2, 19 percent of the women interviewed reported that they were using modern birth-spacing methods. This percentage increased to 32 percent in the final KPC survey.

Acute Respiratory Infection. The objectives were reached for ARI/pneumonia. The percentage of women 15-45 instructed in the prevention of death from pneumonia increased from 31 percent in Year 2 to 46 percent in Year 5, according to the final KPC survey, and 51 percent in the project communities, as identified in the HIS, thus reaching the 50 percent objective. Those who could identify and facilitate treatment of pneumonia in children 0-59 months increased from 46 percent in Year 2 to 54 percent in the general project area at Year 5 and 78 percent in the project communities themselves. The objective of 30 percent was surpassed in Year 2 of the project.

A2. Facilitators and Constraints

The interviews conducted as a component of the evaluation were abundant with examples of aspects of the project which aided in meeting project objectives. The project above all is one of training and health education. Interviewees at several levels, from MSP nurses to promoters and guardians mentioned the participatory educational methods used by promoters in training guardians, along with MSP staff and traditional birth attendants (TBAs), as an aid in meeting project objectives.

Most of the MSP nurses surveyed mentioned that relations improved between the MSP and the community as a direct result of the project. As guardians work closely with the community and refer patients to MSP health centers, community members have demonstrated increased confidence in the MSP system, increased acceptance of the

system, and improved relationships with MSP health care workers, especially the auxiliary nurses. At the same time, nurses have become more knowledgeable about the community and have shown more confidence in both the community, with improved knowledge about its problems, and the health guardian, who is able to assist her: all contributing to reaching joint project-MSP objectives.

In response to recommendations made in the Mid-Term Evaluation, the project strategy was changed to focus on high-risk. The information being collected by guardians and reported to the MSP health center has been reported to be very useful in identifying those at high risk and in contributing to lower child and maternal mortality.

Circumstances less frequently mentioned in interviews with MSP staff and promoters as aiding the project include the following:

- There is an infrastructure to organize the community;
- Mothers are better prepared to care for their children;
- Unvaccinated children can be identified during growth monitoring sessions;
- The logistics system functions well;
- The program of community banks and assistance given to groups of farmers facilitate the fulfillment of objectives; and,
- The good relations established with both the MSP and NGOs greatly facilitated work toward project objectives.

Factors hindering the project in meeting objectives were also identified, as follows:

- In the beginning of the project, gaining acceptance in some communities was difficult. Most promoters were recruited from outside the community because of the difficulty in finding qualified personnel from within. Several promoters were initially rejected by the community at project initiation for various reasons including, lack of support by the MSP, lack of support by a local priest in one case, and lack of knowledge on the part of the community of the sponsoring organization. Most importantly, however, in gaining acceptance was that a change in community expectations of a health project was involved. Most were initially not satisfied with purely preventative services which did not include food, medicine, or other material benefits. Changes in promoters also hindered the project somewhat.
- Interviewees noted a lack of effective integration, and sometimes coordination, of some aspects of the project with the MSP in the first two

years. The guardian-auxiliary nurse relationship was weak before the Mid-Term Evaluation. Circumstances contributing to the lack of integration included frequent changes in MSP personnel. Now that the project is integrated and guardians report to and are supervised by MSP auxiliary nurses, achievement of objectives is still somewhat hindered by health guardians who do not always attend monthly meetings at Health Centers.

- Also mentioned in interviews was that children do not always attend growth monitoring sessions. As growth monitoring sessions are often the place where high-risk children are identified and channeled into other components of the program, most significantly immunization, their lack of attendance is a hinderance to achieving objectives.

- The first year of the project child survival (CS) personnel were unable to obtain commercial ORS packets from the Government of Honduras. Nor were packets available for private purchase. This hindered the work of the guardians and undermined their credibility in the eyes of the community. As an interim strategy, guardians emphasized the home mix in health education sessions until packets again became available in the second project year;

- Because of the many activities required of guardians in Year 1, it became difficult for them to adequately cover the community and to give the necessary attention to mothers. During the second project year, therefore, new strategies were tested including the social marketing of health messages, health education in schools and churches, and recruiting guardians block-by-block in the larger communities. After the Mid-Term Evaluation, the focus on risk groups was intensified to further reduce the workload of the guardians; and,

- The high attrition or rotation rate of health promoters hindered the project throughout. Promoters with the appropriate level of education could not be recruited from within the project communities, with few exceptions. Promoters relocated from others areas often had to return to their homes for family or other reasons out of control of the project.

Unintended benefits identified by project staff or mentioned in interviews include the following:

- As relations between the MSP and the community improved, other programs unrelated to child survival were strengthened, for example, malaria, cholera, and AIDS; and,

- The MSP planned a Vitamin A project after one was initiated by the CS-Guayape (CS-G) Project;

- A continuous devaluation of the Lempira (local currency) compared to the U.S. dollar was observed throughout the project. This produced an increase in local currency available for the project. This increase allowed for the recruitment of additional staff and the training of TBAs during the final project year.

- The project facilitated the success of community banks;

- The image of WRH was enhanced with respect to the MSP, other NGOs, and the community;

- The administrative, technical, and operational skills of WRH personnel were upgraded.

Facilitators and constraints which are intervention specific are listed in Appendix G.

A3. Final Evaluation Survey

A copy of the final 1994 30-cluster Knowledge, Practice, and Coverage (KPC) survey is attached as Appendix I. The results are summarized in the following table:

Summary of Achievements by Indicator
Child Survival-Guayape Project, 1994

Indicator	Achievement (Percent)
1. Initiation of Breastfeeding	66%
2. Exclusive Breastfeeding	55%
3. Introduction of Foods	86%
4. Persistence of Breastfeeding	43%
5. Continued Breastfeeding During Diarrhea	86%
6. Continued Fluids During Diarrhea	65%
7. Continued Foods During Diarrhea	66%
8. ORT Use	44%
9. Medical Treatment for Pneumonia Control	54%
10. EPI Access	93%
11. EPI Coverage	92%
12. Measles Coverage	92%
13. Drop-Out Rate	1.5%
14. Maternal Card	78%
15. Tetanus Toxoid Coverage	73%
16. One or More Ante-Natal Visits	80%
17. Modern Contraceptive Usage	32%

B. Lessons Learned Regarding the Total Project

The main lessons learned regarding the total project that are applicable to other PVO CS projects, and/or relevant to A.I.D.'s support of these projects can be outlined as follows:

1. When a community health volunteer has to handle many interventions, ten is the ideal number of families in order for her to carry out his/her work effectively.

2. It is impossible to improve the nutritional status of children who are already malnourished through training only. An income-generation program is also needed to enable mothers to have the means to buy nutritious foods for their children in Honduras.

3. The development of human resources at the community level is effective because they are able to visualize their problems and simultaneously seek solutions to them.

4. The supervision of field workers should be carried out systematically with the help of simple but reliable instruments, in order to correct the problems found at all CS-G levels in the least time possible.

5. Unless each aspect of the program during all the stages of the Project (the proposal, the health messages, the structures, supervision policies, the health information system, reference system, costs) are developed together with the MSP, there will be no hope of sustainability.

6. In order to have a close relationship with the MSP there should be a strategy (which is effective for the MSP personnel) for motivating and facilitating joint labor and the training of volunteers.

7. It is more effective to train community volunteers if the strategy and the educational content is sensitive to the cultural context.

8. The local health committees, which at the beginning function as support groups for the health volunteers, are very important in order to ensure community participation, but their function should be carefully defined in order for them to be effective.

9. The supervisors of community health volunteers should have well-defined work guidelines regarding whom to work with; for example, with teachers or with churches, etc. If it is left up to them, little is accomplished since they have difficulty knowing where and how to begin working in the community.

10. It is good to emphasize education of the community by means of community volunteers, but it is not effective to have all the work depend exclusively on one type of volunteer, for example, health guardians only. The community should be helped to integrate actions with networks of responsible individuals in the community.

11. At the structural level of the MSP, the auxiliary nurse is the ideal staff person to carry out the work of community education. Where she does not actively participate in the selection and training of community volunteers, there cannot really be an effective integration of the guardian within the MSP structure.

12. The Health Information System (HIS) should be designed from the onset of the Project so as not to lose valuable information. When a revision is needed, the field staff, volunteers and MSP personnel should be given full participation.

13. Health education which cannot provide the necessary resources (for example, contraceptives) is not effective for improving community practices.

14. Health education should not be reduced simply to the transmission of knowledge, but should go farther toward the initiation of practices. For example, the health volunteer should not only give instructions to the mother as to how to prepare ORS but should have the ORS, prepare the solution with the mother, give the first dose to the child, make follow-up visits to the mother to ensure that she is using ORS at home.

15. Since school children are loved and respected by adults, they are excellent educators. Besides, when they are educated, the adults of the future are educated.

16. Health volunteers who have been trained with a curative focus, despite the training they receive, are not able to function well in prevention. Even health personnel at the highest level who have a curative focus have serious difficulties getting involved in preventive activities.

17. Participatory methodologies and techniques are effective in the training of community volunteers. They facilitate learning and the development of skills to train others.

18. In a context where material incentives are not possible, the health volunteer can work effectively with nonmaterial incentives, such as the prestige and knowledge acquired and the sense of importance which the work has for the community, something which is more sustainable than providing material incentives.

19. Growth monitoring sessions having too many participants are not very effective because there is not sufficient time to instruct the mother on the use of the growth chart and on her child's development. In addition, it wears out the health volunteer.

20. The careful recruitment of volunteers and training on the characteristics and functions of the health volunteer are important since they greatly influence whether or not he/she continues.

21. The motivation of the supervisors of community health workers is more important for defining his/her vision and the results of his/her labor than are the materials he/she possesses.

22. The strategy of working with risk groups is important so as not to overburden community personnel.

23. The HIS at the community level should be designed in a way that allows the health volunteer, the nurse, and members of the community to identify the high-risk population easily and the actions that should be carried out.

IV. Project Sustainability

A. Sustainability Status

A1. End of Funding

Funding for the project ends on August 31, 1994.

A2. Termination of Activities

Promoters and most other project staff will cease their child survival project activities at the end of the grant period, August 31, 1994. The child survival director plans to continue for some months after to develop health activities in other areas of the country as well as to ensure as smooth a transition as possible and to strengthen the sustainability of the project.

A3. Transfer of Responsibilities and Control

Much has been done to phase over major project responsibilities to local institutions, especially the MSP.

Before the Mid-Term Evaluation, relationships had been established between guardians and promoters as well as between promoters and MSP nurses and auxiliary nurses, but in many cases, a direct relationship between volunteer health guardians and nurses/auxiliary nurses was weak or non-existent. Since the Mid-Term Evaluation, an effort has been made to strengthen this guardian/auxiliary nurse relationship so that when support is no longer available for promoters, volunteer guardians will be able to continue working under the guidance of the MSP.

During the last two years, the relationship between the guardians and the auxiliary nurse has been greatly strengthened, as frequently noted by interviewees. At the request of WRC, MSP Area Chiefs issued a directive to nurses at the local level to work with WRC volunteer health guardians. Both the WRC promoter and MSP auxiliary nurse have now been participating jointly in supervision of the guardian to strengthen the relationship.

In the majority of the communities visited, guardians now have monthly meetings with the auxiliary nurse at the Health Center. During the meeting, monthly activities are reviewed along with the identification of at-risk cases. Data from the health information system (HIS) are analyzed, and often a plan of action is developed. Guardians report data to the auxiliary nurse to supplement the regular MSP information system, especially on pregnant women, children at nutritional risk as identified in growth monitoring sessions, and children or women lacking immunizations. Since December, 1993, the health information system for which guardians collect data has been located within the Health Center. The health guardians now report data directly to the MSP health centers rather than to the area office of WRH.

In the community of Orica, the promoter withdrew support from guardians to allow them to work directly with the auxiliary nurses. Many promoters reported in interviews that they have worked with auxiliary nurses to train them in how to motivate and retain guardians, and almost all guardians interviewed reported that they would be able to continue working without the support of the promoter because of their strong relationship with the auxiliary nurse. In August/September, 1993, responsibility for the guardians was officially transferred from WRH to the MSP at the regional level.

On-going coordination with the MSP at the central and regional levels, in addition to the local level, has been a component of the project since its initial design. At the regional level, project supervision has been conducted jointly by the WRH Area Coordinators and the MSP Area Chief.

In addition, efforts have been intensified during the final two years of the project to develop health committees in communities where they did not previously exist and strengthen existing ones. Health committees have been providing additional support to guardians since responsibility for their supervision was transferred to the MSP.

Training was also given to teachers to enable them to deliver lessons on children survival within the regular primary school curriculum. Teachers interviewed have indicated that they will be able to continue health lessons with technical support from the MSP when needed.

No other private organization is providing child survival services in the Department of Francisco Morazan or in the areas of Olancho Department where WRH is working. Two other private organizations, however, are providing services in other sections of Olancho Department: El Buen Pastor and PREDISAN. In addition, the Asociación Hondureña de

Planificación Familiar (ASHONPLAFA) is providing family planning services. Although none has the resources to take over project activities, the child survival director is entering into dialogue with these organizations, along with the MSP at the regional level, to explore any ways in which they may be able to support former WRH activities within their own organizations, perhaps involving fund raising. Meetings are planned for each of the two project departments. Steps to organize these meetings had only just begun at the time of the final evaluation, seven weeks before project end. As this effort will likely continue after A.I.D. funding ceases, some project activities could be phased over to one or more of them.

About 20 percent of the promoters have received some support from their churches. Soliciting additional church support for promoters and/or guardians is being discussed.

B. Estimated Recurrent Costs and Projected Revenues

B1. Activities Perceived as Effective by Project Management

Upper WRH management (country and project director) have identified the following activities as those perceived as most effective:

- The use of participative training methods;
- Community work with block representatives;
- The formation of health committees based upon risk groups. In some rural communities, a group of volunteer guardians work together, each taking responsibility for one major activity, such as reproductive health (prenatal care, post-natal care, and newborn care), growth monitoring for children growing well, growth monitoring for children not growing well, control of diarrhea and use of ORT, immunization, and ARI and vitamin A. Each one is trained in all activities but generally works in one area of emphasis. Each, plus the auxiliary nurse, is a member of the health committee which meets every two-four weeks;
- The use of health guardians without monetary remuneration;
- Strengthening relations between the MSP and the community; and,
- Working with other PVOs/NGOs, such as ASHONPLAFA, World Neighbors, and ACPH to facilitate the work of the health guardian.

In a group discussion, members of the project management team jointly identified the following eight activities as most effective:

- Training of community volunteers (health guardians, TBAs, teachers);
- Growth monitoring;
- The Expanded Program in Immunization (EPI);
- The organization of guardians by block;
- Oral Rehydration Therapy (ORT)
- Family planning/management of reproductive risk;
- Exclusive breastfeeding; and,
- Community banks (to respond to hunger in the community).

The first five of the activities were also seen to be most effective by the MSP representatives interviewed, and all were mentioned by at least one MSP staff interviewed.

B2. Expenditures for Recurrent Costs

Several categories of recurrent costs were identified during interviews which would be needed for the project to continue at the same level for at least three more years. The most important by far is that of human resources needed for training and supervision, especially of guardians and TBAs.

Also mentioned were the following expenses:

- Maintenance, repair, and possible replacement of the scales for weighing children at growth monitoring sessions;
- Transportation for guardians when they travel to workshops and other training events;
- Refreshments and lunch for guardians during meetings;
- Nominal incentives, gifts for special occasions, and assistance for medical emergencies; and,
- Paper for forms which guardians use in the information system along with pencils and erasers.

B3. Calculation of Recurrent Costs

The following table displays WRH's calculations for the total amount of money in U.S. dollars the project will need each year, at a minimum, to sustain project benefits for three years after funding ends. As can be seen in the table, the largest expense is for training sessions at $33,000 for three years, following by the salary of supervising nurses (calculated at 25% time) at $21,450, and $19,294 for materials.

Also indicated in the table is the suggested source of funds. WRH recommends that NGOs be considered as a major source of support.

World Relief Honduras
Costs of Project Sustainability (U.S.$)

Item	No.	Monthly	Annually	Three Years	Funding Sources MSP	PVOs/NGOs	Community
Nurses Salaries	22	550	7150	21450	21450	–	–
Training Sessions	12	925	11100	33300	–	33300	–
Materials (notebooks, pencils/sharpeners, erasers, ID, baby pants)	343	19	6431	19294	–	19294	–
Travel Expenses	52	50	2574	7722	3861	3861	–
Maintenance and Repair/Scales	–	–	63	188	–	–	188
Incentives to Guardians	–	–	1050	3150	–	–	3150
TOTALS	**–**	**1543**	**28368**	**85103**	**25311**	**56455**	**3338**

B4. Reasonability of Costs

The recurrent costs calculated above were seen by the evaluation team to be reasonable given the environment in which the project operates. The proportion of costs allocated to PVOs/NGOs, however, may not be absorbed by them. WRH is currently in dialogue with PVOs/NGOs to explore possibilities.

B5. Projected Revenues for Continuation

Projected revenues, in U.S. dollars, that appear likely to fund some child survival activities for at least three years after A.I.D. child survival funding ends are addressed in Section B3.

B6. Unsustainable Costs

The following costs are not likely to be sustainable given the limited resources of the MSP:

- WRC management staff salaries and benefits;
- Promoter staff salaries and benefits;
- Intensive training/retraining efforts, including transportation and meals; and,
- Intensive field supervision.

Of the above costs, field supervision is most important for the sustainability of the project. The MSP could possible use Regional Rotating Funds from the A.I.D./Honduras Health Sector II Project to cover per diem expenses for field supervision. A portion of the costs above may also be sustained if NGOs elect to absorb them.

B7. Financial Lessons Learned

The following lesson was learned with regard to project costs which may be applicable to other child survival projects or to A.I.D.'s support of these projects:

- Community health workers can work effectively without monetary payment which greatly increases the possibility of sustainability; and,
- The cost of sustaining some child survival activities for at least three years is minimal.

C. Sustainability Plan

C1. Project Staff Interviewed

The following project staff were interviewed regarding the sustainability plan:

Number	Position
1	CS Project Director
1	Assistant CS Director
1	CS Administrative Coordinator (Headquarters)
1	Health Educator
2	Area Coordinators
11	Promoters, Area 1
3	Promoters, Area 2

All staff have had substantial involvement in project implementation as well as in monitoring and evaluation. Promoters and staff who were recruited late in the project, such as the Health Educator, have had less involvement in project design.

C2. DIP for Sustainability

The six-part DIP for sustainability can be summarized as follows:

1. WRH planned to foster community ownership and public support of the project by involving health committees and community women in all aspects of project design, implementation, and monitoring and evaluation. Meetings were held to discuss the initial baseline survey not only to identify community priorities but also to involve the community in monitoring and evaluation from the beginning. Qualitative indicators of public support were: (a) support from community leaders, (b) active involvement of community leaders, (c) general interest in the project shown by members of the community, (d) enthusiasm for the project evidenced by the guardian and parents in a community, and (f) successful project management existing at the community level.

2. WRH planned to closely coordinate the project with the MSP as well as collaborate with PVOs. Contact between the health guardians and the MSP nurse was to be promoted as a key component of coordination with the MSP. PVOs especially important in project implementation were identified as El Buen Pastor, PREDISAN, Obreros Cristianos, and ASHONPLAFA.

3. No long-term expatriate staff were to be involved in the project.

4. WRH planned to explore several household income-generating activities. Extensionists would work with small crop-producing families, and activities targeted for women would be funded through community banks. Cost recovery methods were not to be explored.

5. WRH planned to obtain supplies, such as ORS packets, from the MSP. Recurrent costs which would need to be incurred by the MSP after project funding ceased were identified and were seen to be minimal compared to the savings expected in decreased mortality and morbidity.

6. WRH planned to train health guardians, consistent with MSP policy, to phase-over training and supervision of the guardians to the MSP, and to organize community health committees.

C3. Sustainability Activities Carried Out

The sustainability-promoting activities from the initial DIP described above were all carried out over the life of the project. The activities have been described in Sections E3, E4, E5, and F2 of this report.

C4. Implementation of Sustainability Plan

The evaluation team found that all six aspects of the sustainability plan described in the DIP were implemented satisfactorily. Specifically:

1. The community was involved in a participative analysis of the baseline survey results, and the community was involved in project design, implementation, and monitoring and evaluation. All qualitative indicators of public support were found to be present, with the exception of community-level project management which was not fully implemented.

2. WRH closely coordinated the project with the MSP at all levels as well as collaborated with PVOs. Evidence of the close coordination is that support, training, and supervision of the health guardians has been transferred to the MSP, and guardians and MSP auxiliary nurses have been meeting monthly in the majority of Health Centers since last year.

3. No long-term expatriate staff were involved in the project.

4. WRH explored several household income-generating activities, including family gardens, small ranches with groups of fathers, and income-generation activities with groups of mothers organized into community banks. In Area One alone, 175 families cultivated family gardens assisted under the project; 193 cultivated fruit trees; 130 raised animals, and two raised bananas.

5. WRH obtained supplies from the MSP, including ORS packets and literature. In addition, the MSP provided vaccinations. During the last year of the project, Vitamin A was also provided by the MSP.

6. WRH trained health guardians, consistent with MSP policy and phased-over training and supervision of the guardians to the MSP. Health committees were organized, although only 75 of the 118 organized under the project (64%) were active at project end.

Several activities were unplanned in the initial DIP but nonetheless formed an important part of the sustainability efforts. These were identify by management staff as:

- Work with the schools;

  An activity which was unplanned at the beginning of the project but which has played an important part in institutionalizing child survival interventions within the community is that of health education within the primary school curriculum. Promoters have worked with teachers in 48 schools throughout the project area in developing lesson plans for child survival instruction in Grades 1 through 6. Lessons have included: nutrition and breastfeeding, oral rehydration therapy/diarrhea/cholera, immunization, Vitamin A, respiratory infections, and family planning. Many teachers interviewed expressed their support for health education within the school as a community services and stated their intention to continue with health education with each new cohort after the project ends. When prompted, they indicated that they would use the MSP nurse/auxiliary nurse as a resource for refresher training.

  The thrust of the program within the schools has been to teach children who will some day be parents themselves and who can disseminate messages to parents and neighbors. In several cases, they were required to participate in a community cleanup campaign. Children also have participated in gathering mothers for weighing or immunization sessions. In some communities, they have participated in a parade on Children's Day carrying placards with child survival messages. Several teachers commented that the children are seen to be credible sources when repeating what they have learned in school to mothers and neighbors. The program could have been strengthened by motivating children to seek out those at risk, such as neighbors with unvaccinated children, and refer them to the health center.

- Work with the churches;

  Five churches have active health committees comprised of groups of women who act as health guardians within their communities. Others are providing some type of support to promoters or health guardians. Efforts will be continued to increase the support of guardians by churches.

- Training TBAs;

  In accordance with an amendment to the Cooperative Agreement, WRC has trained 590 TBAs. The curriculum included topics such as how to detect and refer high-risk births, personal hygiene and cleanliness, prenatal care, birthing, attention to the newborn, post-natal care, and family planning;

- HIS located in Health Centers;

  Since December 1993, HIS data collected by the guardians has been maintained in each MSP Health Center.

- The community-based HIS;

  A community-based HIS was been developed so that mothers can know when a child dies in her community and if the cause of death is related to any of the child survival interventions. Also graphically displayed in the community are data on children at nutritional risk and cases of diarrhea and ARI.

- The referral/counter-referral system; and,

  See Section F2.

- Joint supervision.

  See Section F2.

C5. Financial Commitments of Counterpart Institutions

The MSP promised to provide ORS packets, vaccinations, educational material, health worker time, and some use of their physical installations. These commitments were generally kept, with the exception of some shortage of ORS packets during the first project year.

In addition, the following PVOs/NGOs provided discounts for services and gifts in kind:

- ASHONPLAFA charged a minimum fee for sterilization to all women referred by WRH;

- El Buen Pastor provided medical care at a very low cost to health guardians during the project and will continue to do so after the project ends; and,

- World Neighbors gives technical assistance to mothers and health guardians free of charge with regard to the production, processing, and storage of foods.

C6. Financial Commitments Kept

Reasons for the success of counterpart institutions to honor commitments include clear and frequent communication with WRH, common objectives and priorities, and good coordination.

D. Monitoring and Evaluation of Sustainability

D1. Sustainability Indicators

The major indicators used to track achievements in sustainability outputs include the number of guardians trained and the number of health committees organized and continuing to function to support them (see table, Section A1 as well as Sections C4 and D2).

D2. Accomplishments in Sustainability

At the end of the project, 399 guardians had been trained, 341 of whom (85%) were still working. The proportion of volunteer guardians retained from initial training through project end was extremely high demonstrating the very strong support given to them by WRC promoters.

A total of 118 health committees of various compositions were organized by end-of-project, with mixed results (see also Section E5). Some committees are very active, and some members have been supporting the guardian since the beginning of the project. In other cases, the committees are only active sporadically, and there is great turnover and desertion on the part of members. A total of 75 health committees were active at the time of the final evaluation.

Progress toward all other child survival objectives can be seen as contributing to sustainability at the household level. Mothers will continue practicing what they have been taught under the WRC project to the extent that child survival interventions become institutionalized and reinforced by MSP personnel, health guardians continuing under the auspices of the MSP, neighbors, health committee members, teachers, and school children.

D3. Qualitative Indicators of Sustainability

A number of qualitative findings from the interviews and from discussions with staff on the evaluation team indicate the sustainability potential of project benefits.

Community participation and motivation is very good as are relations between

community members and guardians. Community members now have confidence in guardians and participate in activities by providing refreshments and lunch during activities, as well as by providing the location for events and assisting the health guardian during weighing and vaccination sessions. As a result of effective health education provided by the guardians, community members have changed practices and increased their knowledge of child survival practices. This has led to a noticeable decrease in morbidity and mortality within the community.

Guardians now have confidence in the nurse auxiliary at the Health Center as well, and most participate in monthly meetings held at the Health Center or, in some cases, within the community. The auxiliary nurses are now supervising and providing on-the-job training to guardians.

D4. Involvement in Evaluations

The following in-country agencies have worked with WRC on the design, implementation, and/or analysis of Mid-Term and Final Evaluations:

Mid-Term: MSP, El Buen Pastor, International Eye Foundation

Final: MSP, El Buen Pastor, International Eye Foundation, ASHONPLAFA, Ministries of Christian Service, Ministries of Christian Service

D5. Feedback on Sustainability Recommendations

WRH received feedback on the recommendations regarding sustainability made by the technical reviewers of the proposal and DIP, and the recommendations were generally carried out.

The recommendations made with regard to the proposal which pertain to sustainability include the selection and training of guardians and the health committee system. The technical review of the DIP correctly points out that the DIP appropriately addressed the recommendations made in the original proposal review.

WRH also received some feedback on sustainability issues in the DIP, although feedback largely addressed technical areas. One concern was the dropout rate for unpaid guardians. This was not found to be a problem. As was pointed out in Section D2, of the 399 guardians who had been trained, 341 (85%) were still working at the end of the project.

D6. Implementation of Mid-Term Recommendations

Nine recommendations were made concerning sustainability in the midterm evaluation (see list of midterm recommendations in Appendix H). The response to each recommendation will be addressed separately:

1. Recommendations were made to increase the sustainability of growth monitoring and vaccination and were carried out in full. Specifically, the program revolves around growth monitoring, and a focus on risk was successfully implemented. Health committees and block representatives have been instrumental in identifying children at risk because of lack of vaccination. With regard to diarrhea control, demonstrations of ORS preparation were recommended. Each guardian has ORS packets in the home and is prepared to demonstrate its preparation as well as to demonstrate its preparation during health education sessions.

2. A system of referral/counterreferral was established, as recommended in the evaluation. The formats were designed by the MSP and reproduced by WRH. Both guardians and TBAs are using the forms.

3. Recommendations concerning supervision instruments were carried. Supervision formats and plans of action for supervision were developed and are being followed.

4. Recommendations concerning the data system were largely carried out. Specifically:

   - The HIS is now concentrated in the health center (see Section A3);
   - Data handling was formally reviewed and improved;
   - A system of reporting data to the community was established (see Section C4);
   - The exchange of information on recommendations and experiences was promoted. The CS Project Director has shared lessons learned in Peru, Nicaragua, El Salvador, Guatemala, Mexico, the Dominican Republic.
     Exchange of information is also promoted by headquarter's CS staff who attend international health conferences and are in contact with other international PVOs and WRC field offices. Information and resource materials from these PVOs are sent to the WRH field office regularly.

One recommendation, that WRH share information regularly by means of a news bulletin was not carried out. The project was not seen to be large enough to justify a separate news bulletin.

5. All recommendations regarding technical aspects of community participation were carried out.

6. As recommended, a one-week workshop was held on the issues addressed with participation by the MSP and 10 private organizations.

7. A number of recommendations were made for operations research studies on cost recovery and other issues. Only one operations research study was conducted to investigate the impact of fostering relationships between community banks and health. Operations research was generally seen to be beyond the budget and time limitations of staff. (For a discussion of cost recovery, see Section I.)

8. The recommendation was made to identify technical assistance for the HIS and nutrition. During the month of August 1993, the HIS was revised with the consultant, Dr. Alejandro Melara Vega. During the month of May 1993, nutritionist Mario Nieto gave a training workshop to all the Child Survival Project staff on Child Nutrition.

9. It was suggested that other sources of funding be sought for additional technical assistance. During the period of August 1992 to January 1993 the Project contributed to the training of 150 MSP field staff in Olancho Department and of all the health promoters of the Project. Previously, the Project Director had been trained by the Pan American Health Organization (PAHO) and he multiplied this training to form facilitators among the personnel directing the CS-G and the MSP doctors and nurses. The materials used in the training process were obtained by the Project from PAHO in Washington.

E. Community Participation

E1. Community Leaders and Members Interviewed

Community leaders/members interviewed were as follows:

Health Guardians

María Cefalea Castro	San Ignacio, Francisco Morazán
María Teresa Luque	San Ignacio, Francisco Morazán
Rosalinda Soto	San Ignacio, Francisco Morazán
Blanca Azucena Escoto	San Ignacio, Francisco Morazán
Ada Antúnez	El Guayabito, Olancho
Amanda Varela	El Guayabito, Olancho
Victoria Rodríguez	El Guayabito, Olancho
Jenny Gonzáles	El Guayabito, Olancho
Emelda Licona	El Guayabito, Olancho
Martina Portillo	El Guayabito, Olancho
Francis de Gómez	Catacamas, Olancho
Blanca Velásquez	Catacamas, Olancho
Vilma Suyapa de Claros	Catacamas, Olancho
Norma Lizeth Ramos	Catacamas, Olancho
Emelda Licona	Catacamas, Olancho
Martina Porillo	Catacamas, Olancho
María Carmen Licona	Orica, Francisco Morazán
Corina Figueroa	Orica, Francisco Morazán
Nohemí Figueroa	Orica, Francisco Morazán
María del Carmen Licona	Orica, Francisco Morazán
Reina Isabel Lanza	Orica, Francisco Morazán
Marilia Maradiaga	Orica, Francisco Morazán
Reina Isabel Reyes	Orica, Francisco Morazán
German Barahona	Guayape, Olancho
Emeria Dominga Méndez Coello	San Cristobal, Francisco Morazán
María de la Cruz Ramírez	Escano de Tepale, F.M.
Olga Doris Aguiriamo	Campo Nuevo, Olancho
María de Jesús Maldonado	Casas Viejas, Olancho
Digna Morales	Siguaté, Olancho
Edvidia Avila Cruz	La Concepción, Olancho

Husbands of Guardians

German Barahona	El Convento, Olancho
Oscar Armando Coello	Orica, Francisco Morazán

Teachers

Rosbinda Leticia López	San Ignacio, Francisco Morazán
Lusbinda Guzmán	San Ignacio, Francisco Morazán
María Mendoza	Catacamas, Olancho
Adiled Avila	Sta. María del Real, Olancho
Ilda M. Cruz	Sta. María del Real, Olancho
Carlos Guevara	Sta. María del Real, Olancho
Rita Villalobos	Sta. María del Real, Olancho
Concepción Avila	Sta. María del Real, Olancho
Mirna Mejía	Sta. María del Real, Olancho
Francisca Guevara	Sta. María del Real, Olancho
Deysi Mendoza	Sta. María del Real, Olancho
Rosario Mendoza	Sta. María del Real, Olancho
Sandra Santos	Sta. María del Real, Olancho
Ma. Ana López	Sta. María del Real, Olancho
María Elena Zavala Mejía	Guayape, Olancho
Ramón Abelardo Ponce	Guayape, Olancho
Bartolomé Cartajena Sánchez	Guayape, Olancho
Casta Argentina Aguilar	San Cristobal, Francisco Morazán
Sonia Matilde Bustillo	Escano de Tepale, Francisco Morazán
Rosa Núñez	Escano de Tepale, Francisco Morazán
Olger Escoto	Escano de Tepale, Francisco Morazán

Mothers

Rosa Amalia Ortiz	Escano de Tepale, Francisco Morazán
María Olivia Barahona	Escano de Tepale, Francisco Morazán
Doris Isabel Matute	Escano de Tepale, Francisco Morazán
Dominga Brito	Orica, Francisco Morazán
Elia Brito	Orica, Francisco Morazán
Delmi Corina Figeroa	Orica, Francisco Morazána Avila
Raimunda Avila	Catacamas, Olancho
Juana Francisca Lopez	San Cristobal, San Ignacio
Reina Margarita Andino	San Ignacio, Francisco Morazán
Ritza Lorena Laínez	San Ignacio, Francisco Morazán
Ana Dolores Sandoval	San Ignacio, Francisco Morazán
Socorro López	San Ignacio, Francisco Morazán
Rosa Isabel Amador	San Ignacio, Francisco Morazán
Gloria Matute	Guayape, Olancho
Bertha Bejarano	Guayape, Olancho
Concepción Sevilla	Guayape, Olancho
María Vargas	Guayape, Olancho
Salomé Lobo	Guayape, Olancho

Floridalma Reyes	Guayape, Olancho
Trinidad Alvarado	Guayape, Olancho
María Gladis Varela	Guayape, Olancho
Reina del Carmen Canales	Guayape, Olancho
Maura Ortiz	Guayape, Olancho
Nieves Moradel	Guayape, Olancho
Dora Cerrato	Guayape, Olancho
Lilian Cáceres	Guayape, Olancho
Ana Besy Merlo	Guayape, Olancho

Community Health Committee Members

Erica Melania Velásquez	Sta. María del Real, Olancho
María Luisa Cruz	Sta. María del Real, Olancho
María del Socorro Rodríguez	Sta. María del Real, Olancho
Digna Maribel Martínez	Sta. María del Real, Olancho
María Carmen Licona	Orica, Francisco Morazán
Gonsalina Alvarez	Guayape, Olancho
Sonia Lisset Orellana	Guayape, Olancho
Francisca Merita Sánchez	Guayape, Olancho
Amanda Varela de Antúnez	El Guayabito, Olancho
Ada Antúnez de Cáliz	El Guayabito, Olancho
Yeni Gonzáles	El Guayabito, Olancho
Victoria Rodríguez	El Guayabito, Olancho
Theodora Maldonado	Casas Viejas, Olancho
Martha Gricelda Cruz	Casas Viejas, Olancho
Angela Gonzales	Casas Viejas, Olancho
Alejandrina Zavala	Casas Viejas, Olancho
Rumualda Morales	Casas Viejas, Olancho
Visitación Zavala	Casas Viejas, Olancho
Victoria Gonzales	Casas Viejas, Olancho
Cirilia Mejia	Casas Viejas, Olancho
Idalia Maribal Maldonado	Casas Viejas, Olancho
Cecilia Fletes	Escano de Tepale, Francisco Morazán
Carla Cabreras	Escano de Tepale, Francisco Morazán
Josefa López	Escano de Tepale, Francisco Morazán
Vedalma Maradiaga	Escano de Tepale, Francisco Morazán

Community Bank Members

Enma Montoya de Cruz	BC-El Triunfo, Catacamas, Olancho
Martha Irene Baca	BC-El Triunfo, Catacamas, Olancho
Angela Estela Rivera	BC-El Triunfo, Catacamas, Olancho
Francisca Nunez	BC-El Triunfo, Catacamas, Olancho

Doris Alicia Euceda	BC-El Triunfo, Catacamas, Olancho
Yolanda Rosales	BC-El Triunfo, Catacamas, Olancho
María Asteria Palacios	Vallecito, Olancho
Natividad Mejía	Vallecito, Olancho
Aída Gutiérrez	Vallecito, Olancho
Alicia Martínez	Vallecito, Olancho
María Inestroza	Vallecito, Olancho
Francisca Reyes	Vallecito, Olancho
Reyna Paz	Vallecito, Olancho
María Asteria Palacios	Catacamas, Olancho

Community Banks/Health Guardians

Consuelo Hernández	Catacamas, Olancho
Rosmunda Avila	Catacamas, Olancho
María Consuelo Oliva	Catacamas, Olancho
Juana Erazo	Catacamas, Olancho

Church Members/Health Guardians

Claribel Mejía	Catacamas, Olancho
María Geraldina Aceituno	Catacamas, Olancho
Carla Colindres	Catacamas, Olancho

E2. Activities Perceived as Effective by the Community

Mothers, teachers, guardians, and members of health committees were asked which project activities they saw to be most effective. The following six activities were mentioned most frequently:

- Growth monitoring sessions;
- Immunization;
- Control of diarrhea;
- Control of respiratory infections;
- Hygiene;
- Vitamin A; and,
- Family planning.

A variety of other activities were mentioned less frequently in interviews, including health education, nutrition, nutrition, AIDS and sexually transmitted diseases, cholera, malaria, breastfeeding, community banks, community participation, prevention in general, and prenatal care.

E3. Empowering Communities

Above all, interviewees identified health education, training, (of health guardians, nurses, health committee members, teachers, and church members), and improving relations between the community and the MSP Health Centers to have been the most useful in empowering the communities to better meet their basic needs.

Other means identified of empowering the community have included contributing to the development of:

- Community banks;
- A focus on risk;
- Improved access of the community to health services;
- A community-based information system;
- A community organized for preventive mother/child health;
- Selecting, training, and promoting church leaders and school teachers;
- Food production by means of family gardens and collectives of small farmers; and,
- Demonstrations of how to prepare nutritious foods.

E4. Community Participation

Members of the community were involved in project design, implementation, and evaluation.

Community members greatly influenced the following during project design:

- Developing school lessons;
- Soliciting basic health services;
- Requesting family gardens; and,
- Developing the information system.

There is extensive community participation in project implementation, on the part of volunteer guardians, health committees, teachers, school children, church members, community bank members, and mothers. Each participant plays a role in diffusing basic messages.

The volunteer health guardian plays the strongest role. She provides basic preventive health services and health education in child survival interventions addressed by the project. In addition, she collects data from the community and reports it to the MSP auxiliary nurse. She sometimes provides training for a new health guardian.

Health committees have assumed a variety of different roles in the implementation of the CS V project, according to their desires and the wishes of the community. Some play an advisory or work planning role, whereas others are more participatory. In some, each members has separate and often very specific tasks to perform related to the child survival program. In the case of one health committee whose members were interviewed in Catacamas, for example, one member specializes in pre-natal care, one in immunization, and another in family planning. Health committee members and mothers frequently assist the guardian in weighing children and during vaccination sessions. Others have assisted in demonstrations of how to prepare food nutritiously. Members sometimes help in training a new health guardian, especially those committee members who are guardians themselves. Some have provided food or organized short-term feeding programs for malnourished children.

Community banks also support the CS V project. Some community banks have their own health guardian who provides services, such as weighing children, during bank meetings. Community banks also help to increase family income, often contributing to improved family nutrition.

Teachers instruct children in the primary Grades 1 through 6 in child survival interventions and organize their participation in clean-up campaigns and parades. Schools

provide educational materials and classrooms for instruction.

School children, participate in parades to disseminate health messages, especially on Children's Day and Independence Day. School children also participate in environmental cleanup campaigns.

Mothers participate in all interventions by bringing their children for services. In addition, they often assist in weighing and vaccination sessions as well. Some mothers bring refreshments or food during health education sessions or provide the location for the session to be held.

Church members participate in all of the interventions. In addition, some churches give special support to promoters and/or guardians who are church members.

In-depth individual and group interviews were held with guardians, health committee members, teachers, church members, community bank members, and mothers to obtain their input regarding project problems, successes, and sustainability for the final evaluation. All but teachers were also interviewed during the mid-term evaluation. Also, as previously mentioned, the health guardians had substantial input on the design of the information system which provided data to determine whether project objectives were met during the evaluations.

E5. Health Committees

According to area coordinators, there are a total of 75 active health committees in the two departments addressed by the project. Each meets every two to four weeks.

Health committees have varying compositions, but two basic models have been followed. In one case, health committees are comprised of volunteer guardians working in nearby areas. This model is more prevalent in Francisco Morazan Department where guardians are working sometimes at the block level. In the second case, health committee members are usually community leaders and are very much in touch with and representative of their communities.

E6. Significant Issues of Health Committees

According to members of health committees, as well as other community members, the most significant issues currently being addressed by them are the following:

- Growth monitoring;
- Providing latrines and maintaining a clean community;
- Acute respiratory infections;

- Control of diarrhea and cholera. (Note: There was a cholera epidemic during the second year of the project, and cases were being reported during the final evaluation.);
- Referrals;
- Sexually transmitted diseases; and,
- Family planning.

(Note: Interviewees did not always distinguish between health committees organized by WRH and by the MSP. Latrines and sexually transmitted diseases were generally not issues dealt with under CS-G.)

E7. Community Contributions to Sustainability

The resources the community has been providing during project implementation continue to be provided and will all contribute to the continuation of activities after funding ends.

As detailed in Section E4, the community, above all, provides human resources: the health guardian and members of health committees. Other community members support the activities of the health guardian by assisting her in vaccination and growth monitoring sessions, assisting with food demonstrations, providing food for malnourished children, bringing refreshments or food during health education sessions, and providing the location for sessions to be held.

E8. Success/Failure of Health Committees

The major factor contributing to the success or failure of health committees to contribute resources toward the continuation of effective project activities is the relationship between the committee and the guardian which each supports. Also important is its relationship with the MSP auxiliary nurse and whether or not it continues to meet regularly.

A health committees fails when the MSP auxiliary nurse does not support it, treats the members badly, or when the community rejects it or the activities which it plans.

F. Ability and Willingness of Counterpart Institutions to Sustain Activities

F1. Persons Interviewed from Counterpart Institutions

The following persons from counterpart institutions were interviewed:

Region 7 MSP Minister

Hector Luis Escoto	Juticalpa, Olancho

Area No. 1, Chief

Luis Barahona	Sanitary Region 7, MSP, Juticalpa

Regional MSP Maternal/Child Director

Aida Figueroa	Juticalpa, Olancho

Area Supervisor

Carmen de Lanza	Catacamas, Olancho

Health Center Nurse Supervisors/Nurses/Auxiliary Nurses

Argelia Castillo (AN)	Escano de Tepale, Francisco Morazán
Gloria Díaz (AN)	Sta. María del Real, Olancho
Miriam Carpio (NS)	Talanga, Francisco Morazán
Lilian Esmeralda Sevilla (NS)	Guayape, Olancho
Claudia Gómez (SN)	Talanga, Francisco Morazán
Carmen Torres (SN)	Talanga, Francisco Morazán
Dulcesina Urbina (SN)	Talanga, Francisco Moraz
Ilsi Licona (AN)	Guayape, Olancho
Anarda Agurcia (AN)	Orica, Francisco Morazán
Alba Luz Murillo (AN)	Orica, Francisco Morazán
Olga de Izaguirre (AN)	San Ignacio, Francisco Morazan
Danubia Zelaya (AN)	Río Tinto, Olancho
Daysi Barahona (AN)	Siguaté, Olancho

Private Voluntary Organizations

Nestor Salavarría	El Buen Pastor, Catacamas, Olancho
Luis Alonzo Gonzáles	ASHONPLAFA, Juticalpa, Olancho
José Domingo Henriquez	ASHONPLAFA, Region 7 Promoter

See also Section F2 for the relationship of the above organizations to the project.

F2. Linkages between the Project, the MSP, and Private Organizations

The project is being coordinated with both central and regional MSP officials, including conducting supervision visits and coordinating meetings and workshops.

By far, the most important linkage, however, is between health guardians and MSP auxiliary nurses at the local level (see also Section A3). The support being given to each guardian by the auxiliary nurse, and vice versa, is an important key to the sustainability of the project. The promoter has been supervising guardians together with the auxiliary nurse in order to strengthen that relationship. The established referral system, whereby guardians refers clients to the Health Center and the auxiliary nurse gives a counter-referral to the guardian, also helps to strengthen this link. The auxiliary nurse helps to train the guardian in monthly meetings at which time the guardian shares the information collected from the community during the month. The information system developed by the project is now being maintained within each Health Center.

World Relief has also trained MSP staff in child survival interventions and assisted with transportation and logistics.

World Relief has linkages to a number of private organizations, including most importantly ASHONPLAFA, the Asociacion Cultural Popular de Honduras (ACPH), and El Buen Pastor.

ASHONPLAFA has assisted in training guardians, mothers, teachers, and school children and has provided contraceptives and sterilization services to the project. ASHONPLAFA volunteers have participated as members of health committees which support the work of the guardian. WR guardians refer community members to ASHONPLAFA family planning posts. When mothers desire sterilization and cannot pay for this service completely on their own, WR will pay a portion of the costs. WRH, which has credibility within the communities, has enabled ASHONPLAFA to work in the communities which were previously closed to its services.

ACPH has assisted the project by providing resources for sectorial meetings and seeds for family gardens. It has also provided transportation and other logistical support to promoters.

El Buen Pastor Clinic has provided logistical support and supplies, including computer use, transportation, and training materials. The Director has been giving technical support, without charge, to the project since its beginning. The Clinic also offers medical care to guardians at a very low cost.

WR coordinates some activities with a number of other private organizations. With World Neighbors, WR has coordinated the production, processing, and storage of food as well as growth monitoring and health education. With Pastoral Social, guardians have been trained in traditional medicine. Experiences, lessons learned, and the results of studies are shared with World Vision, Save the Children, PLAN/Honduras, **Project HOPE,** Adventist Development and Relief Association (ADRA), and others.

F3. Institutions Key in Sustaining Activities

The MSP is the key institution expected to take part in sustaining project activities by providing supervision, training, and other support to volunteer guardians.

Other institutions expected to play a role in sustainability include ACPH, El Buen Pastor, World Neighbors, primary schools, health committees, and evangelical churches.

F4. Activities Perceived as Effective by MSP/Private Institutions

MSP personnel and staff of key local organizations have identified the following activities as most effective:

- Training of personnel (guardians, TBAs, teachers);
- Growth monitoring;
- The Expanded Program in Immunization (EPI);
- Acute respiratory infections;
- The organization of guardians by block; and,
- Oral Rehydration Therapy (ORT);

Others mentioned less frequently include:

- Family planning/management of reproductive risk;
- Exclusive breastfeeding;
- Community banks (to respond to hunger in the community); and,
- Vitamin A.

F5. Skill-Building within the MSP and Other Institutions

WRH has helped to build skills of local MSP personnel in a number of ways. MSP staff, especially nurses and auxiliary nurses, were trained in the technical content of the child survival interventions, as were health guardians, using an interactive method. In addition, they were trained by promoters in how to work with and supervise community volunteers and how to identify groups at high risk. Through this training, they have learned to trust the volunteer health guardians and to believe in their potential.

With regard to the information system, MSP staff have been taught how to use local resources to develop data collection instruments and to develop retrieval systems. The data collected by the health guardians is being reported to MSP staff and maintained within the local Health Center.

Primary school teachers were trained in interactive educational methods and in technical areas of child survival. Each was also given a set of technical materials. This training often resulted in an attitude change in the teachers toward their increased perception of the value of preventive health. They are now involved in educating the community in public health through its school children.

Personnel from other PVOs/NGOs have also been included in training activities. For example, in November, 1992, a workshop was held on ARI/CDD for staff from both the MSP and 10 NGOs.

F6. MSP Resources for Sustainability

The MSP is able to provide some financial, human, and material resources to sustain effective project activities once child survival funding ends. Specifically, the MSP is able to provide auxiliary nurses, to train, supervise, and support the guardians, especially during monthly meetings. MSP staff interviewed consistently stated that they would support the project but that training and supervision could not be maintained at the same level as was being provided by WRH. Some stated that money was not available to provide food and transportation to the training site for volunteer guardians. Health committees and guardians themselves, however, often stated that they were trained well enough to be able to train new guardians. Some guardians had already done so. Health committees and guardians are expected to supplement the MSP's more limited ability to train new guardians.

MSP Health Centers also support guardians by offering free medical services to them and their children. In general, however, the MSP cannot offer incentives which imply costs. An important non-monetary incentive which they confer, however, is prestige within the community. Some MSP Health Centers are able to provide materials to guardians.

F7. Activities Perceived as Effective

Please see Section F4 of this report for project activities that counterpart organizations perceive as effective.

G. Project Expenditures

G1. Pipeline Analysis

The final pipeline analysis of country and HQ expenditures is attached in Appendix A.

G2. Planned vs. Actual Expenditures

The actual total expenditures of the project (country and headquarters), compared to the budget reported in the first annual report, was underspent by $56,343 for the A.I.D. contribution and $14,533 for WRC, with total underspendings of $70,876. (Note: The first annual report budget was the same as the DIP budget, except for indirect costs which were not calculated correctly in the DIP, but were corrected in the first annual report. Therefore, the first annual report budget has been used for this comparison.)

With regard to the country budget, all major line items were underspent, when compared to the first annual report budget, except for WRC procurement costs (overspent by $26,799) due to higher than expected equipment costs. Other program costs were underspent, primarily due to underexpenditures in personnel ($119,431 A.I.D. and $33,787 WRC) which resulted from the devaluation of the Lempira. Evaluation costs were overspent by $7,652 AID and $1,899 WRC. A.I.D. "other direct costs" were overspent by $70,699.

As personnel was so underspent and insufficient funds were originally budgeted for evaluation, the Cooperative Agreement was amended to increase the evaluation line item and allow some monies originally budgeted for personnel to be used for a new TBA training program, reported under "personnel" and "other direct costs." If end-of-project spending is compared to the amended rather than the original budget, underspending for personnel is reduced; and spending for "evaluation" and "other direct costs" are on target.

With regard to the headquarter's budget, actual expenditures were within $219 dollars of what was originally budgeted.

G3. Competency of Handling Finances

Funds were managed in a clear, competent manner, following the budget, and were classified according to line items predetermined by A.I.D. and according to the Cooperative Agreement, as amended.

G4. Lessons Learned for Expenditures

Lessons learned with regard to project expenditures that might be helpful to other PVOs or relevant to A.I.D.'s support strategy include the following:

- Funds should be budgeted for equipment maintenance, repair, and/or replacement, as needed. Equipment, such as photocopiers and scales, often need to be replaced; and,

- The budget for evaluation should be based on costs similar projects have incurred in recent years to avoid over- or under-budgeting.

H. Attempts to Increase Efficiency

H1. Efficiency Strategies

Low cost strategies and methods, such as the use of local resources for educational materials and conducting training locally, were used for all aspects of the project to increase efficiency and the potential for sustainability. The following strategies were implemented:

- Designing training events within the working area of each promoter;

- Maintaining costs low so that the MSP will be able to sustain them;

- Making data collection forms by hand with paper from the community;

- Using local resources in training, the HIS, and administration in general;

- Training locally and in the afternoons. This allows health guardians to finish tasks in their homes and reduced the cost of meals during workshops;

- Using materials produced by the MSP and other organizations so as not to duplicate efforts;

- Using local means of transportation or coordinate transportation with other organizations;

- Using community resources to the maximum extent possible, i.e. in preparing foods, selecting training locations which can be used free of charge, and use of local transportation;

- Motivating health guardians without monetary remuneration;

- Decentralizing project administration into two area offices and 11 work zones;
- Sharing the cost of events with other NGOs and the MSP;
- Supervising and monitoring area- and zone-level costs at the central level;
- Applying a system for procuring goods and services at the central office in volume and at times when low prices can be negotiated;
- Using of non-monetary incentives for health volunteers;
- Recruiting personnel with strong moral convictions;
- The promoters use the facilities and furniture of the health center in lieu of a separate office;
- Progressively increasing salaries to personnel to offset inflation and maintain motivation; and,
- Reimbursing personnel trip expenses at a modest level.

H2. Success/Failure of Efficiency Attempts

The strategies detailed above were all successfully used to reduce costs or increase productivity or efficiency. An additional reason for the success of attempts to increase efficiency is the fact that project personal work long hours without pay for overtime.

H3. Lessons Learned Regarding Efficiency

The following were identified by WRH CS management staff as lessons learned regarding attempts to increase efficiency that might be applicable to other PVO child survival projects or to A.I.D.'s support of these projects:

- It is possible to successfully train following development principles; and,
- The use of locally-available materials for training permits the guardians to more easily train other guardians.

I. Cost Recovery Attempts

No cost-recovery mechanisms were implemented. The DIP pointed out that the feasibility and acceptability of cost-recovery methods would not be tested since MSP policy is to provide all child survival interventions and supplies free of charge. Although there are examples of successful community pharmacies in Honduras, the WRH project did not have a curative focus.

J. Household Income Generation

J1. Household Income-Generating Activities

During the last quarter of the second project year, an income generation program was implemented throughout the project areas in order to generate income at the household level. A total of three percent of the project budget was used in community banks. The following activities were implemented:

- Credit and technical assistance to mothers through community banks for income-generating activities.
- Credit and technical assistance to men to cultivate traditional crops (chile, tomatos, corn, beans, and pineapple); and,
- Family gardens.

J2. Increase in Annual Family Income

The dollar amount added to the household annual income as a result of income-generating activities is unknown as those interviewed did not want to or were unable to answer this question.

J3. Contribution to Health Activities

The percentage of revenues contributed by income-generating activities which was used for the cost of health activities is unknown.

J4. Lessons Learned Regarding Household Income Generation

The following lessons learned with regard to household income generation which may be applicable to other child survival projects or to A.I.D.'s support strategy were identified by project management:

- The presence of income-generating activities stimulates and facilitates child survival activities;
- Training in health during community bank meetings increases the likelihood that mothers are thinking about the health of their children when they make decisions regarding the use of new income; and,
- Income-generation activities offer alternatives to break the cycle of poverty that underlies health problems in the population.

K. Summary of Findings

K1. Achievement of Objectives

Above all, training, health education, and improving relations between the community and the MSP health centers were found to be the most useful in terms of empowering the communities to better meet their basic health needs with a package of effective interventions likely to be sustainable.

A total of 399 health guardians had been trained during the project, 85 percent of whom were still working at project end. The retention rate for health guardians was outstanding in comparison with similar child survival projects worldwide. Of 118 health committees organized during the project, 75 were actively working to support the health guardian at the end of the project.

The success of the guardians in educating the community can best be seen by examining the child survival indicators. Most of the objectives proposed in the DIP were achieved or nearly achieved. At the end of the project, 88 percent of children 12-23 months were completely immunized; 74 percent of children 0-23 months in the project communities were being weighed monthly; almost all women were breastfeeding, 68 percent exclusively for the first four months; the majority of post-partum women 15-45 and children 6-59 months had received Vitamin A; 80 percent had received prenatal care; 27 percent were using family planning; and 78 percent of mothers 15-45 could identify and facilitate the treatment of pneumonia.

The project was less successful in terms of ORT use. Only 58 percent of mothers were using it although 75 percent knew how. Nonetheless, MSP nurses reported that cases of dehydration presented at health centers had greatly decreased. The proportion of mothers instructed in breastfeeding, weaning, and nutrition was approximately two-thirds the objective.

Progress toward child survival objectives can be seen as contributing to sustainability at the household level. Mothers will continue practicing what they have been taught under the project to the extent that the interventions become institutionalized and reinforced by MSP personnel, health guardians continuing under the auspices of the MSP, neighbors, health committee members, teachers, and school children.

K2. Achievement of Sustainability

The evaluation team found that WRH had been very successful in promoting project sustainability by closely coordinating the project with the MSP, especially at the regional and local levels, from the beginning of the project and by transferring responsibility for training and supervision of the health guardians to the MSP at the end of the project. In

August/September, 1993, responsibility for the guardians was officially transferred from WRH to the MSP at the regional level. Since December, 1993, the HIS developed under the project has been located within the local MSP health centers, and guardians now report data directly to the center.

K3. Summary of Sustainability Lessons Learned

The following were identified by the evaluation team as the lessons learned with regard to sustainability:

1. Unless each aspect of the program during all the stages of the Project (the proposal, the health messages, the structures, supervision policies, the health information system, reference system, costs) are developed together with the MSP, there will be no hope of sustainability.

2. In order to have a close relationship with the MSP there should be a strategy (which is effective for the MSP personnel) for motivating and facilitating joint labor and the training of health guardians.

3. The development of human resources at the community level is effective because they are able to visualize their problems and simultaneously seek solutions to them.

4. The local health committees, which at the beginning function as support groups for the health volunteers, are very important in order to ensure community participation, but their function should be carefully defined in order for them to be effective.

5. It is good to emphasize education of the community by means of community volunteers, but it is not effective to have all the work depend exclusively on one type of volunteer, for example, health guardians only. The community should be helped to integrate actions with networks of responsible individuals in the community.

6. At the structural level of the MSP, the auxiliary nurse is the ideal staff person to carry out the work of community education. Where she does not actively participate in the selection and training of community volunteers, there cannot really be an effective integration of the guardian within the MSP structure.

7. The HIS should be designed from the onset of the Project so as not to lose valuable information. When a revision is needed, the field staff, volunteers and MSP personnel should be given full participation.

8. Since school children are loved and respected by adults, they are excellent educators. Besides, when they are educated the adults of the future are educated.

9. In a context where material incentives are not possible, the health volunteer can work effectively with nonmaterial incentives, such as the prestige and knowledge acquired and the sense of importance which the work has for the community, something which is more sustainable.

10. The careful recruitment of volunteers and training on the characteristics and functions of the health volunteer are important since they are decisive in whether or not he/she continues.

L. Key Recommendations

Following are the key recommendations of the evaluation team with regard to the MSP, non-governmental organizations (NGOs), and A.I.D.:

MSP

- The MSP, at both regional and local levels, should ensure that its health personal at the local level, especially auxiliary nurses, are involved in the health activities carried out by volunteers by directing, supervising, and motivating them;

- The MSP should include in its budget a line item for expenses for supervision and training of community volunteers or use funds from the A.I.D./Honduras Regional Rotating Fund for this purpose;

NGOs

- NGOs should strengthen their coordination with the MSP at all levels of their projects;

- NGOs should not give cash payment to community volunteers so that the community may continue working without assistance from the NGO in the future; and,

- NGOs should use community resources in training community volunteers.

A.I.D.

- As it is impossible to achieve changes in health practices of the population with short-term projects, each project should be for a minimum of five years; and,

- The reporting guidelines and requirements should be simplified to allow more time for project staff to work directly with the community.

WRH

- The external consultant recommends that WRH continue dialogue with private organizations, including NGOs, churches, and community groups, to explore ways in which they may be able to support former WRH activities within their own organizations.

An earlier draft of these recommendations was discussed with representatives of A.I.D./Honduras, Office of Health, and was modified according to their suggestions.

V. Evaluation Team

A1. List of Team Members

Loida Clotter, External Evaluator, Ministries of Christian Service
Joel Durón Rodriguez, Assistant CS Director
Lisa Filoramo, WRC CS Administrative Coordinator
Carlos Hernandez, Health Educator
Roberto Ruiz Pineda, Country Director
La Rue K. Seims, External Consultant and Team Leader
Guadalupe Solís, CS Area No. 1 Coordinator
Hector Luis Velasquez, CS Area No. 2 Coordinator
Orestes Zuniga Rivas, CS Project Director

The evaluation report was prepared by the Team Leader, La Rue K. Seims, with assistance from all team members.

A2. Study Methodology

The evaluation took place from July 4 to July 16. The team included two external evaluators and WRH project staff.

In initial meetings, members of the evaluation team reviewed the Scope of Work for the evaluation (see Appendix A), extracted data on indicators from surveys and other

reports, identified relevant documents to be reviewed (Appendix C), and identified the persons, or categories of persons, who had been influential in design, implementation, or evaluation of the project and those who would affect its sustainability. The team prepared guides for field interviews, using the FHA/PVC 1993 Final Evaluation Guidelines for CS-VI Projects, since the guidelines for CS-VII projects had not yet been received. Guides for group discussions to analyze and synthesize the information collected were also developed. (See Appendix E for interview guides.) The schedule and plan for field visits was also determined. (See Appendix F for the evaluation schedule.)

It was decided to compare indicator data collected for goals and objectives in the baseline survey, two KPC surveys, and the health information system maintained by health guardians.

The eight-person evaluation team divided into two groups for field interviews: Groups A and B. Group A generally included La Rue K. Seims, Guadalupe Solís, Hector Luis Velasquez, and Orestes Zuniga; and Group B generally included Loida Clotter, Joel Durón, Lisa Filoramo, and Carlos Hernandez.

For six days, the two teams visited municipalities and villages conducting in-depth, qualitative interviews using the guides prepared. The guides were only guides. Questions were adapted according to the local language and understanding of interviewees, and questions outside the guides were often asked. Any questions found difficult for interviewees to understand were discussed between the two teams and adapted in the field.

Group A conducted interviews in Talanga, Orica, San Cristobal, Guayape, Catacamas, and Juticalpa. Group B conducted interviews in San Ignacio, Escano de Tepale, Catacamas, Rio Tinto, Siguate, Campo Nuevo, Casas Viejas, Corralites, and Juticalpa. Those interviewed, by position and location, are included in Appendix D. Their numbers and positions are summarized as follows:

Number	Position
1	MSP Region 7 Minister
1	MSP Area Chief
1	MSP Regional Maternal/Child Health Director
1	MSP Area Supervisor
13	MSP Nurse Supervisors/Nurses/Auxiliary Nurses
14	WRH Promoters
30	WRH Health Guardians
21	Teachers
27	Mothers
25	Community Health Committee Members
14	Community Bank Members

4	Community Banks/Health Guardians
3	Private Voluntary Organizations
3	Church Members/Health Guardians
2	A.I.D.

One day was spent discussing, synthesizing, summarizing, and analyzing findings while in Catacamas. Summaries were developed on flipcharts. Additional meetings of the evaluation team were held in Tegucigalpa to discuss lessons learned and recommendations. The recommendations developed were shared with A.I.D./Honduras.

Appendices

Appendix A: Pipeline Analysis

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HEADQUARTERS PROJECT PIPELINE ANALYSIS GUAYAPE CS

	ACTUAL EXPENDITURES TO DATE HEADQUARTERS EXPENSE SEP/1/89--AUG/31/94			REMAINING OBLIGATED FUNDS			TOTAL HQ AGREEMENT BUDGET SEP/1/89--AUG/31/94		
	USAID	WRC	TOTAL	USAID	WRC	TOTAL	USAID	WRC	TOTAL
TOTAL FIELD EXPENSE	865,978.79	288,426.16	1,154,404.95	(558.79)	6,703.84	6,145.05	865,420.00	295,130.00	1,160,550.00
TOTAL HEADQUARTER EXPENSE	134,021.21	45,993.88	180,015.09	558.79	(23.88)	534.91	134,580.00	45,970.00	180,550.00
GRAND TOTALS YRS 1-5	1,000,000.00	334,420.04	1,334,420.04	(0.00)	6,679.96	6,679.96	1,000,000.00	341,100.00	1,341,100.00

Printed 12-Dec-94

HEADQUARTERS PROJECT PIPELINE ANALYSIS GUAYAPE CS

HEADQUARTERS	ACTUAL EXPENDITURES TO DATE HEADQUARTERS EXPENSE SEP/1/89--AUG/31/94			REMAINING OBLIGATED FUNDS			TOTAL HQ AGREEMENT BUDGET SEP/1/89--AUG/31/94		
	USAID	WRC	TOTAL	USAID	WRC	TOTAL	USAID	WRC	TOTAL
PROCUREMENT									
Equipment:	0.00	814.09	814.09	0.00	(401.09)	(401.09)	0.00	413.00	413.00
Supplies:	694.29	46.80	741.09	489.71	378.20	867.91	1,184.00	425.00	1,609.00
Consultants									
1) Local:	44.99	75.01	120.00	0.01	(0.01)	(0.00)	45.00	75.00	120.00
2) Expatriate:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
TOTAL PROCUREMENT	739.28	935.90	1,675.18	489.72	(22.90)	466.82	1,229.00	913.00	2,142.00
EVALUATION	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
INDIRECT COSTS	25,096.77	0.00	25,096.77	75.23	0.00	75.23	25,172.00	0.00	25,172.00
OTHER PROGRAM COSTS									
Personnel									
1) Health	59,986.96	6,876.75	66,863.71	(18.96)	0.25	(18.71)	59,968.00	6,877.00	66,845.00
2) Administrative	42,697.50	10,228.44	52,925.94	20.50	(0.44)	20.06	42,718.00	10,228.00	52,946.00
3) Other	484.20	19,293.06	19,777.26	9.80	(0.06)	9.74	494.00	19,293.00	19,787.00
Travel/Per Diem									
1) In Country	5,016.50	0.00	5,016.50	(17.50)	0.00	(17.50)	4,999.00	0.00	4,999.00
2) International	0.00	6,685.45	6,685.45	0.00	(0.45)	(0.45)	0.00	6,685.00	6,685.00
Other Direct Costs	0.00	1,974.28	1,974.28	0.00	(0.28)	(0.28)	0.00	1,974.00	1,974.00
TOTAL OTHER PRG COSTS	108,185.16	45,057.98	153,243.14	(6.16)	(0.98)	(7.14)	108,179.00	45,057.00	153,236.00
TOTAL EXPENSES TO DATE	134,021.21	45,993.88	180,015.09	558.79	(23.88)	534.91	134,580.00	45,970.00	180,550.00

NOTE: On July 14, 1992, in preparation for FY93, it was decided to move (a) $2000 from Procurement (WRC/Supplies) to use for Personnel (WRC/Health) and (b) $1500 from ODC (WRC) to Personnel ($720 Health and $780 Admin). Therefore, the Total HQ Agreement Budget was adjusted.

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COUNTRY PROJECT PIPELINE ANALYSIS GUAYAPE CSP

FIELD	ACTUAL EXPENDITURES TO DATE WRH COUNTRY EXPENSE SEP/1/89--AUG/31/94			REMAINING OBLIGATED FUNDS			TOTAL CTRY AGREEMENT BUDGET SEP/1/89--AUG/31/94		
	USAID	WRC	TOTAL	USAID	WRC	TOTAL	USAID	WRC	TOTAL
PROCUREMENT									
Equipment:	6,312.42	96,293.06	102,605.48	0.58	(0.06)	0.52	6,313.00	96,293.00	102,606.00
Supplies:	20,077.15	2,055.80	22,132.95	372.85	0.20	373.05	20,450.00	2,056.00	22,506.00
Services:	65.43	0.00	65.43	799.57	0.00	799.57	865.00	0.00	865.00
Consultants									
1) Local:	8,903.42	0.00	8,903.42	3,754.58	0.00	3,754.58	12,658.00	0.00	12,658.00
2) Expatriate:	1,849.38	0.00	1,849.38	(0.38)	0.00	(0.38)	1,849.00	0.00	1,849.00
TOTAL PROCUREMENT	37,207.80	98,348.86	135,556.66	4,927.20	0.14	4,927.34	42,135.00	98,349.00	140,484.00
EVALUATION	13,174.98	1,653.85	14,828.83	727.02	596.15	1,323.17	13,902.00	2,250.00	16,152.00
INDIRECT COSTS	199,420.97	0.00	199,420.97	(37,622.97)	0.00	(37,622.97)	161,798.00	0.00	161,798.00
OTHER PROGRAM COSTS									
Personnel									
1) Health	308,787.87	28,028.98	336,816.85	566.13	12,755.02	13,321.15	309,354.00	40,784.00	350,138.00
2) Administrative	113,343.54	90,348.48	203,692.02	402.46	(17,903.48)	(17,501.02)	113,746.00	72,445.00	186,191.00
3) Other	17,209.98	32,350.74	49,560.73	5,681.02	10,339.26	16,020.27	22,891.00	42,690.00	65,581.00
Travel/Per Diem									
1) In Country	16,744.24	5,034.62	21,778.86	263.76	(1,645.62)	(1,381.86)	17,008.00	3,389.00	20,397.00
2) International	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other Direct Costs	152,142.22	30,740.49	182,882.72	20,936.78	1,590.51	22,527.28	173,079.00	32,331.00	205,410.00
TOTAL OTHER PRG COSTS	608,227.86	186,503.32	794,731.18	27,850.14	5,135.68	32,985.82	636,078.00	191,639.00	827,717.00
EXCHANGE (GAIN)/LOSS	7,947.18	1,920.13	9,867.31	3,559.82	971.87	4,531.69	11,507.00	2,892.00	14,399.00
TOTAL EXPENSES TO DATE	865,978.79	288,426.16	1,154,404.95	(558.79)	6,703.84	6,145.05	865,420.00	295,130.00	1,160,550.00

Appendix B: Scope of Work

WORLD RELIEF CORPORATION/HONDURAS
GUAYAPE CHILD SURVIVAL V PROJECT

FINAL EVALUATION
SCOPE OF WORK

PURPOSE

To assess the accomplishment and sustainability potential of WRC's Guayape Child Survival V Project in accordance with the guidelines established in their .Cooperative Agreement (OTR-0500-A00-9157) and the Detailed Implementation Plan (DIP).

EVALUATION OUTPUTS

The evaluator will be responsible for preparing and delivering an original unbound copy and four bound copies of the final report, in English, to USAID/Washington and one unbound copy to WRC/Wheaton by September 7, 1994.

Prior to this, the evaluator will present a rough draft in Spanish, with tentative recommendations, to the evaluation committee and Guayape Child Survival field staff for discussion on July 14, 1994. A second draft in Spanish will be sent to the Guayape Child Staff in Honduras by August 11, 1994 for their final review. This draft will be returned to the evaluator with comments by August 18, 1994.

The report should provide the following:

1. An assessment of WRC's achievements with regards to the goals of the Grant Agreement and the DIP.

2. An assessment of the constraints that influenced the achievement of any of the established goals at the close of the Project (September 1994).

3. Recommendations to WRC do support (over the next 3 years) gains achieved in the target communities during the initial project period.

The body of the report should follow the USAID Final Evaluation Guidelines (attached) and contain the following:

- Table of Contents
- Executive Summary
- Key Findings and Recommendations
- Team Composition and Study Methodology
- Annexes
- Scope of Work
- List of Documents Consulted
- List of Individuals/Organizations Consulted

METHODOLOGY

The evaluation team will conduct its assessment based on the following:

1. WRC Cooperative Agreement with FHA/PVC, DIP, annual reports and technical reviews.

2. WRC's responsiveness to recommendations in the various technical reviews of project documents.

3. Results of the final KPC Survey.

4. Other documents considered relevant by the evaluation team.

5. Interviews with Guayape Child Survival Project staff, beneficiaries, MOH, USAID, and other individuals considered relevant.

ISSUES TO BE ADDRESSED

The Guayape Project staff have designated sustainability of project gains as a priority focus for the evaluation.

Appendix C: List of Documents Consulted

Bonegas, Yesica, *et. al.*, **Training Memorandum on Training Traditional Birth Attendants**, December 1993.

Cooperative Agreement and Amendment

Correspondence files, April-July 1994

Curriculum and Action Messages for Diarrheal Diseases, 1991.

Curriculum and Basic Messages on Acute Respiratory Infections, 1992.

Curriculum for Nutrition, 1990.

Curriculum for Training Health Guardians in Vitamin A, 1993.

"Honduras Guayape Child Survival V Project, First Annual Report," World Relief Corporation, September 1, 1989-August 31, 1990.

"Honduras Guayape Child Survival V Project, Second Annual Report," World Relief Corporation, September 1, 1990-August 31, 1991.

"Honduras Guayape Child Survival V Project, 1993 Annual Report," World Relief Corporation, October 28, 1993.

"Honduras Guayape Child Survival Project, Detailed Implementation Plan," World Relief Corporation, September 1, 1989-August 31, 1994.

"Investigacion de Base, 1990," World Relief Honduras, Diciembre 1990.

"Investigacion Sobre Conocimientos, Practicas, y Coberturas, en Supervivencia Infantil," Proyecto de Supervivencia Infantile - Guayape, Junio de 1994.

"Investigacion Sobre Conocimientos y Practicas en Supervivencia Infantile, 1991," Proyecto de Supervivencia Infantile - Guayape, Mayo 1991.

Lara, Victor, **Midterm Evaluation: Child Survival V, Guayape**, World Relief Corporation/Honduras, September 1992, in English and Spanish.

Martínez, Laura, *et. al.*, **Manual Para La Capacitacion de Parteras Tradicionales en Honduras**, Ministerio de Salud Publica, Tegucigalpa, 1994.

"Metodologia de Educación Participativa," World Relief de Honduras, Tegucigalpa, Junio 1994.

"Proyecto de Capacitacion en Riesgo Reproductivo Centrado en Parteras Tradicionales, Tegucigalpa, Febrero, 1994.

"Report of the Implementation of 7 Community Banks Presented to Tear Fund Belgium," Tegucigalpa, Honduras, November 1993.

Technical Review of CSV DIPS: WRC/Honduras, A.I.D./Washington, undated.

Technical Review by A.I.D. of the Nutrition Curriculum, PSI-G

Research Bulletin, KAP, PSI-G, 1991

1989 CS Proposal Review, A.I.D./Washington, April 1989.

Appendix D: List of Individuals/Organizations Interviewed

Region 7 MSP Minister

Hector Luis Escoto	Juticalpa, Olancho

Area No. 1, Chief

Luis Barahona	Sanitary Region 7, MSP, Juticalpa

Regional MSP Maternal/Child Director

Aida Figueroa	Juticalpa, Olancho

Area Supervisor

Carmen de Lanza	Catacamas, Olancho

Health Center Nurse Supervisors/Nurses/Auxiliary Nurses

Argelia Castillo (AN)	Escano de Tepale, Francisco Morazán
Gloria Díaz (AN)	Sta. María del Real, Olancho
Miriam Carpio (NS)	Talanga, Francisco Morazán
Lilian Esmeralda Sevilla (NS)	Guayape, Olancho
Claudia Gómez (SN)	Talanga, Francisco Morazán
Carmen Torres (SN)	Talanga, Francisco Morazán
Dulcesina Urbina (SN)	Talanga, Francisco Moraz
Ilsi Licona (AN)	Guayape, Olancho
Anarda Agurcia (AN)	Orica, Francisco Morazán
Alba Luz Murillo (AN)	Orica, Francisco Morazán
Olga de Izaguirre (AN)	San Ignacio, Francisco Morazan
Danubia Zelaya (AN)	Río Tinto, Olancho
Daysi Barahona (AN)	Siguaté, Olancho

Health Promoters

Area No. 1

Iris Rodríguez	Catacamas, Olancho
José U. Suazo	Catacamas, Olancho
Lesly Juares	Catacamas, Olancho
Jairo Eloc Torres	Catacamas, Olancho
Concepción Soto	Catacamas, Olancho
Dacia Melara	Catacamas, Olancho
Mary Santos	Catacamas, Olancho
Ana Bertha Zavala	Bacadillas, Olancho
Harvy Barahona	Siguaté, Olancho
María Zavala	Dulce Nombre de Culmí, Olancho
Carlos Eduardo Mazzoni	Río Tinto, Olancho

Area No. 2

Alfonso Hernández	Orica, Francisco Morazán
Sulma Esperanza Vallecillo	San Ignacio, Francisco Morazán
Adalid Barahona	Guayape, Olancho

Health Guardians

María Cefalea Castro	San Ignacio, Francisco Morazán
María Teresa Luque	San Ignacio, Francisco Morazán
Rosalinda Soto	San Ignacio, Francisco Morazán
Blanca Azucena Escoto	San Ignacio, Francisco Morazán
Ada Antúnez	El Guayabito, Olancho
Amanda Varela	El Guayabito, Olancho
Victoria Rodríguez	El Guayabito, Olancho
Jenny Gonzáles	El Guayabito, Olancho
Emelda Licona	El Guayabito, Olancho
Martina Portillo	El Guayabito, Olancho
Francis de Gómez	Catacamas, Olancho
Blanca Velásquez	Catacamas, Olancho
Vilma Suyapa de Claros	Catacamas, Olancho
Norma Lizeth Ramos	Catacamas, Olancho
Emelda Licona	Catacamas, Olancho
Martina Porillo	Catacamas, Olancho
María Carmen Licona	Orica, Francisco Morazán
Corina Figueroa	Orica, Francisco Morazán
Nohemí Figueroa	Orica, Francisco Morazán
María del Carmen Licona	Orica, Francisco Morazán
Reina Isabel Lanza	Orica, Francisco Morazán
Marilia Maradiaga	Orica, Francisco Morazán
Reina Isabel Reyes	Orica, Francisco Morazán

German Barahona	Guayape, Olancho
María de la Cruz Ramírez	Escano de Tepale, F.M.
Emeria Dominga Méndez Coello	San Cristobal, Francisco Morazán
Olga Doris Aguiriamo	Campo Nuevo, Olancho
María de Jesús Maldonado	Casas Viejas, Olancho
Digna Morales	Siguaté, Olancho
Edvidia Avila Cruz	La Concepción, Olancho

Husbands of Guardians

German Barahona	El Convento, Olancho
Oscar Armando Coello	Orica, Francisco Morazán

Teachers

Rosbinda Leticia López	San Ignacio, Francisco Morazán
Lusbinda Guzmán	San Ignacio, Francisco Morazán
María Mendoza	Catacamas, Olancho
Adiled Avila	Sta. María del Real, Olancho
Ilda M. Cruz	Sta. María del Real, Olancho
Carlos Guevara	Sta. María del Real, Olancho
Rita Villalobos	Sta. María del Real, Olancho
Concepción Avila	Sta. María del Real, Olancho
Mirna Mejía	Sta. María del Real, Olancho
Francisca Guevara	Sta. María del Real, Olancho
Deysi Mendoza	Sta. María del Real, Olancho
Rosario Mendoza	Sta. María del Real, Olancho
Sandra Santos	Sta. María del Real, Olancho
Ma. Ana López	Sta. María del Real, Olancho
María Elena Zavala Mejía	Guayape, Olancho
Ramón Abelardo Ponce	Guayape, Olancho
Bartolomé Cartajena Sánchez	Guayape, Olancho
Casta Argentina Aguilar	San Cristobal, Francisco Morazán
Sonia Matilde Bustillo	Escano de Tepale, Francisco Morazán
Rosa Núñez	Escano de Tepale, Francisco Morazán
Olger Escoto	Escano de Tepale, Francisco Morazán

Mothers

Rosa Amalia Ortiz	Escano de Tepale, Francisco Morazán
María Olivia Barahona	Escano de Tepale, Francisco Morazán
Doris Isabel Matute	Escano de Tepale, Francisco Morazán
Dominga Brito	Orica, Francisco Morazán
Elia Brito	Orica, Francisco Morazán
Delmi Corina Figeroa	Orica, Francisco Morazána Avila
Raimunda Avila	Catacamas, Olancho

Juana Francisca Lopez	San Cristobal, San Ignacio
Reina Margarita Andino	San Ignacio, Francisco Morazán
Ritza Lorena Laínez	San Ignacio, Francisco Morazán
Ana Dolores Sandoval	San Ignacio, Francisco Morazán
Socorro López	San Ignacio, Francisco Morazán
Rosa Isabel Amador	San Ignacio, Francisco Morazán
Gloria Matute	Guayape, Olancho
Bertha Bejarano	Guayape, Olancho
Concepción Sevilla	Guayape, Olancho
María Vargas	Guayape, Olancho
Salomé Lobo	Guayape, Olancho
Floridalma Reyes	Guayape, Olancho
Trinidad Alvarado	Guayape, Olancho
María Gladis Varela	Guayape, Olancho
Reina del Carmen Canales	Guayape, Olancho
Maura Ortiz	Guayape, Olancho
Nieves Moradel	Guayape, Olancho
Dora Cerrato	Guayape, Olancho
Lilian Cáceres	Guayape, Olancho
Ana Besy Merlo	Guayape, Olancho

Community Health Committee Members

Erica Melania Velásquez	Sta. María del Real, Olancho
María Luisa Cruz	Sta. María del Real, Olancho
María del Socorro Rodríguez	Sta. María del Real, Olancho
Digna Maribel Martínez	Sta. María del Real, Olancho
María Carmen Licona	Orica, Francisco Morazán
Gonsalina Alvarez	Guayape, Olancho
Sonia Lisset Orellana	Guayape, Olancho
Francisca Merita Sánchez	Guayape, Olancho
Amanda Varela de Antúnez	El Guayabito, Olancho
Ada Antúnez de Cáliz	El Guayabito, Olancho
Yeni Gonzáles	El Guayabito, Olancho
Victoria Rodríguez	El Guayabito, Olancho
Theodora Maldonado	Casas Viejas, Olancho
Martha Gricelda Cruz	Casas Viejas, Olancho
Angela Gonzales	Casas Viejas, Olancho
Alejandrina Zavala	Casas Viejas, Olancho
Rumualda Morales	Casas Viejas, Olancho
Visitación Zavala	Casas Viejas, Olancho
Victoria Gonzales	Casas Viejas, Olancho
Cirilia Mejia	Casas Viejas, Olancho
Idalia Maribal Maldonado	Casas Viejas, Olancho
Cecilia Fletes	Escano de Tepale, Francisco Morazán
Carla Cabreras	Escano de Tepale, Francisco Morazán

Josefa López	Escano de Tepale, Francisco Morazán
Vedalma Maradiaga	Escano de Tepale, Francisco Morazán

Community Bank Members

Enma Montoya de Cruz	BC-El Triunfo, Catacamas, Olancho
Martha Irene Baca	BC-El Triunfo, Catacamas, Olancho
Angela Estela Rivera	BC-El Triunfo, Catacamas, Olancho
Francisca Nunez	BC-El Triunfo, Catacamas, Olancho
Doris Alicia Euceda	BC-El Triunfo, Catacamas, Olancho
Yolanda Rosales	BC-El Triunfo, Catacamas, Olancho
María Asteria Palacios	Vallecito, Olancho
Natividad Mejía	Vallecito, Olancho
Aída Gutiérrez	Vallecito, Olancho
Alicia Martínez	Vallecito, Olancho
María Inestroza	Vallecito, Olancho
Francisca Reyes	Vallecito, Olancho
Reyna Paz	Vallecito, Olancho
María Asteria Palacios	Catacamas, Olancho

Community Banks/Health Guardians

Consuelo Hernández	Catacamas, Olancho
Rosmunda Avila	Catacamas, Olancho
María Consuelo Oliva	Catacamas, Olancho
Juana Erazo	Catacamas, Olancho

Church Members/Health Guardians

Claribel Mejía	Catacamas, Olancho
María Geraldina Aceituno	Catacamas, Olancho
Carla Colindres	Catacamas, Olancho

Private Voluntary Organizations

Nestor Salavarría	El Buen Pastor, Catacamas, Olancho
Luis Alonzo Gonzáles	ASHONPLAFA, Juticalpa, Olancho
José Domingo Henriquez	ASHONPLAFA, Region 7 Promoter

A.I.D.

David Losk	Tegucigalpa
Stanley Terrill	Tegucigalpa

Appendix E:Guides Used in Interviews

Interview of the Executive Director

II. PROJECT SUSTAINABILITY

B. Estimated Recurrent Costs and Projected Revenues

B1. Identify the key child survival activities that project management perceives as most effective and would like to see sustained.

B2. What expenditures will continue to be needed (i.e. recurrent costs) if these key child survival activities are to continue for at least three years after child survival funding ends?

B3. What is the total amount of money in US dollars the project calculates will be needed each year to sustain the minimum of project benefits for three years after CS funding ends?

B4. Are these costs reasonable given the environment in which the project operates? (e.g. local capacity to absorb cost per beneficiary)

B5. What are the projected revenues in US dollars that appear likely to fund some child survival activities for at least three years after AID CS funding ends?

B6. Identify costs which are not likely to be sustainable.

B7. Are there any lessons to be learned from this projection of costs and revenues that might be applicable to other child survival projects, or to AID's support of those projects?

C. Sustainability Plan

C3. Describe what sustainability-promoting activities were actually carried out by the PVO over the lifetime of the project.

C4. Indicate which aspects of the sustainability plan the PVO implemented satisfactorily, and which steps were never initiated. Identify any activities which were unplanned, but formed an important aspect of the PVOs sustainability effort.

C5. Did any counterpart institutions (MOH, development agencies, local NGOs, etc.), make a financial commitment to sustain project benefits? If so, have these commitments been kept?

Executive Director (2)

C6. What are the reasons given for the success or failure of the counterpart institutions to keep their commitment?

E. Community Participation

E4. How did communities participate in the design, implementation and/or evaluation of child survival activities?

F. Ability and Willingness of Counterpart Institutions to Sustain Activities

F3. What are the key local institutions the PVO expects to take part in sustaining project activities?

G. Project Expenditures

G1. Attach a pipeline analysis of the project's expenditures.

G2. Compare the budget for planned expenditures identified in the DIP with the actual expenditures at the end of the project. Were some categories of expenditures much higher or lower than originally planned?

G3. Did the project handle the finances in a competent manner?

G4. Are there any lessons to be learned regarding project expenditures that might be helpful to other PVO projects, or relevant to AID's support strategy?

H. Attempts to Increase Efficiency

H1. What strategies did the PVO implement to reduce costs, increase productivity, or make the project more efficient?

H2. What are the reasons for the success or failure of the attempts to reduce costs, increase productivity or efficiency of this project?

H3. Are there any lessons to be learned regarding attempts to increase efficiency that might be applicable to other PVO child survival projects or to AID's support of these projects?

Executive Director (3)

I. Cost Recovery Attempts

I1. What specific cost-recovery mechanisms did the PVO implement to offset project expenditures? If cost recovery was part of the project, who managed implementation?

I2. Estimate the dollar amount of cost recovery obtained during the project. What percent of project costs did this revenue cover? Did the cost recovery mechanisms generate enough money to justify the effort and funds required to implement the mechanisms?

I3. What effect did any cost recovery activity have on the PVOs reputation in the community? Did the cost recovery venture result in any inequities in service delivery?

I4. What are the reasons for the success or failure of the household income generating activities of this project?

I5. Are there any lessons to be learned regarding cost recovery that might be applicable to other PVO child survival projects or to AID's support strategies?

J. Household Income Generation

J1. Did the project implement any household income-generating activities?

J2. Estimate the dollar amount added to a family or household's annual income, as a result of the income-generating activity of the project.

J3. did the revenues contribute to meeting the cost of health activities? What percentage of project costs did income generation cover?

J4. Are there any lessons to be learned regarding household income generation that might be applicable to other PVO child survival projects or to AID's support strategy?

Interview of the CSP-G Director

II. PROJECT SUSTAINABILITY

A. Sustainability Status

A2. At what point does the organization plan to cease child survival project activities?

B. Estimated Recurrent Costs and Projected Revenues

B2. What expenditures will continue to be needed (i.e. recurrent costs) if these key child survival activities are to continue for at least three years after child survival funding ends?

B3. What is the total amount of money in US dollars the project calculates will be needed each year to sustain the minimum of project benefits for three years after CS funding ends?

B4. Are these costs reasonable given the environment in which the project operates? (e.g. local capacity to absorb cost per beneficiary)

B5. What are the projected revenues in US dollars that appear likely to fund some child survival activities for at least three years after AID CS funding ends?

B6. Identify costs which are not likely to be sustainable.

B7. Are there any lessons to be learned from this projection of costs and revenues that might be applicable to other child survival projects, or to AID's support of those projects?

C. Sustainability Plan

C3. Describe what sustainability-promoting activities were actually carried out by the PVO over the lifetime of the project.

C4. Indicate which aspects of the sustainability plan the PVO implemented satisfactorily, and which steps were never initiated. Identify any activities which were unplanned, but formed an important aspect of the PVOs sustainability effort.

C5. Did any counterpart institutions (MOH, development agencies, local NGOs, etc.), make a financial commitment to sustain project benefits? If so, have these commitments been kept?

C6. What are the reasons given for the success or failure of the counterpart institutions to keep their commitment?

D. Monitoring and Evaluation of Sustainability

D2. Do these indicators show any accomplishments in sustainability?

D4. Identify in-country agencies who worked with the PVO on the design, implementation, or analysis of the midterm evaluation and this final evaluation.

D5. Did the PVO receive feedback on the recommendations regarding sustainability made by the technical reviewers of the proposal and DIP? Did the PVO carry out those recommendations? If not, why not?

D6. Did the PVO carry out the recommendations regarding sustainability of the midterm evaluation team? If not, why not?

E. Community Participation

E3. What activities did the PVO carry out to enable the communities to better meet their basic needs and increase their ability to sustain effective child survival project activities?

E4. How did communities participate in the design, implementation and/or evaluation of child survival activities?

F. Ability and Willingness of Counterpart Institutions to Sustain Activities

F3. What are the key local institutions the PVO expects to take part in sustaining project activities?

F5. What did the PVO do to build skills of local MOH personnel or staff of key counterpart NGOs? did they teach them to train CHWs or manage child survival activities once AID funding terminates?

G. Project Expenditures

G1. Attach a pipeline analysis of the project's expenditures.

G2. Compare the budget for planned expenditures identified in the DIP with the actual expenditures at the end of the project. Were some categories of expenditures much higher or lower than originally planned?

G3. Did the project handle the finances in a competent manner?

G4. Are there any lessons to be learned regarding project expenditures that might be helpful to other PVO projects, or relevant to AID's support strategy?

H. Attempts to Increase Efficiency

H1. What strategies did the PVO implement to reduce costs, increase productivity, or make the project more efficient?

H2. What are the reasons for the success or failure of the attempts to reduce costs, increase productivity or efficiency of this project?

H3. Are there any lessons to be learned regarding attempts to increase efficiency that might be applicable to other PVO child survival projects or to AID's support of these projects?

I. Cost Recovery Attempts

I1. What specific cost-recovery mechanisms did the PVO implement to offset project expenditures? If cost recovery was part of the project, who managed implementation?

I2. Estimate the dollar amount of cost recovery obtained during the project. What percent of project costs did this revenue cover? Did the cost recovery mechanisms generate enough money to justify the effort and funds required to implement the mechanisms?

I3. What effect did any cost recovery activity have on the PVOs reputation in the community? Did the cost recovery venture result in any inequities in service delivery?

I4. What are the reasons for the success or failure of the household income generating activities of this project?

I5. Are there any lessons to be learned regarding cost recovery that might be applicable to other PVO child survival projects or to AID's support strategies?

J. Household Income Generation

J1. Did the project implement any household income-generating activities?

J2. Estimate the dollar amount added to a family or household's annual income, as a result of the income-generating activity of the project.

J3. did the revenues contribute to meeting the cost of health activities? What percentage of project costs did income generation cover?

J4. Are there any lessons to be learned regarding household income generation that might be applicable to other PVO child survival projects or to AID's support strategy?

Interview of the Project Team

Field Assistant
Area 1 Coordinator
Area 2 Coordinator
Educator

II. PROJECT SUSTAINABILITY

A. Sustainability Status

A3. How have major project responsibilities and control been phased over to local institutions? If this has not been done, what are the plan and schedule?

B. Estimated Recurrent Costs and Projected Revenues

B1. Identify the key child survival activities that project management perceives as most effective and would like to see sustained.

B6. Identify costs which are not likely to be sustainable.

C. Sustainability Plan

C3. Describe what sustainability-promoting activities were actually carried out by the PVO over the lifetime of the project.

C4. Indicate which aspects of the sustainability plan the PVO implemented satisfactorily, and which steps were never initiated. Identify any activities which were unplanned, but formed an important aspect of the PVOs sustainability effort.

D. Monitoring and Evaluation of Sustainability

D2. Do these indicators show any accomplishments in sustainability?

D3. What qualitative data does the PVO have indicating a change in the sustainability potential of project benefits?

D5. Did the PVO receive feedback on the recommendations regarding sustainability made by the technical reviewers of the proposal and DIP? Did the PVO carry out those recommendations? If not, why not?

Project Team (2)

D6. Did the PVO carry out the recommendations regarding sustainability of the midterm evaluation team? If not, why not?

E. Community Participation

E3. What activities did the PVO carry out to enable the communities to better meet their basic needs and increase their ability to sustain effective child survival project activities?

E4. How did communities participate in the design, implementation and/or evaluation of child survival activities?

E5. What is the number of functioning health committees in the project area? How often has each met during the past six months? Please comment on whether committee members seem representative of their communities.

E7. What resources has the community contributed that will encourage continuation of project activities after donor funding ends?

E8. What are the reasons for the success or failure of the committees to contribute resources for continuation of effective project activities?

F. Ability and Willingness of Counterpart Institutions to Sustain Activities

F2. What linkages exist between the child survival project and the activities of key health development agencies (local/municipal/district/provincial/ state level)?

F3. What are the key local institutions the PVO expects to take part in sustaining project activities?

F5. What did the PVO do to build skills of local MOH personnel or staff of key counterpart NGOs? did they teach them to train CHWs or manage child survival activities once AID funding terminates?

H. Attempts to Increase Efficiency

H2. What are the reasons for the success or failure of the attempts to reduce costs, increase productivity or efficiency of this project?

Project Team (3)

H3. Are there any lessons to be learned regarding attempts to increase efficiency that might be applicable to other PVO child survival projects or to AID's support of these projects?

Interview of Promotors

I. SUMMARY OF PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

A2. Describe any circumstances which may have aided or hindered the project in meeting these objectives, and explain any unintended benefits of project activities.

II. PROJECT SUSTAINABILITY

A. Sustainability Status

A3. How have major project responsibilities and control been phased over to local institutions? If this has not been done, what are the plan and schedule?

C. Sustainability Plan

C3. Describe what sustainability-promoting activities were actually carried out by the PVO over the lifetime of the project.

C4. Indicate which aspects of the sustainability plan the PVO implemented satisfactorily, and which steps were never initiated. Identify any activities which were unplanned, but formed an important aspect of the PVOs sustainability effort.

D. Monitoring and Evaluation of Sustainability

D3. What qualitative data does the PVO have indicating a change in the sustainability potential of project benefits?

E. Community Participation

E3. What activities did the PVO carry out to enable the communities to better meet their basic needs and increase their ability to sustain effective child survival project activities?

E4. How did communities participate in the design, implementation and/or evaluation of child survival activities?

Promotors (2)

E5. What is the number of functioning health committees in the project area? How often has each met during the past six months? Please comment on whether committee members seem representative of their communities.

E6. What are the most significant issues currently being addressed by these health committees?

E7. What resources has the community contributed that will encourage continuation of project activities after donor funding ends?

E8. What are the reasons for the success or failure of the committees to contribute resources for continuation of effective project activities?

F. Ability and Willingness of Counterpart Institutions to Sustain Activities

F2. What linkages exist between the child survival project and the activities of key health development agencies (local/municipal/district/provincial/ state level)?

F3. What are the key local institutions the PVO expects to take part in sustaining project activities?

F5. What did the PVO do to build skills of local MOH personnel or staff of key counterpart NGOs? did they teach them to train CHWs or manage child survival activities once AID funding terminates?

Interview of the Mothers

II. PROJECT SUSTAINABILITY

E. Community Participation

E2. Which child survival activities do community members and leaders perceive as being effective at meeting current health needs?

E6. What are the most significant issues currently being addressed by these health committees?

E7. What resources has the community contributed that will encourage continuation of project activities after donor funding ends?

Interview of the Members of the Health Committees (Leaders)

II. PROJECT SUSTAINABILITY

E. Community Participation

E2. Which child survival activities do community members and leaders perceive as being effective at meeting current health needs?

E3. What activities did the PVO carry out to enable the communities to better meet their basic needs and increase their ability to sustain effective child survival project activities?

E4. How did communities participate in the design, implementation and/or evaluation of child survival activities?

E6. What are the most significant issues currently being addressed by these health committees?

E7. What resources has the community contributed that will encourage continuation of project activities after donor funding ends?

E8. What are the reasons for the success or failure of the committees to contribute resources for continuation of effective project activities?

Interview of the Health Guardians

II. PROJECT SUSTAINABILITY

E. Community Participation

E2. Which child survival activities do community members and leaders perceive as being effective at meeting current health needs?

E3. What activities did the PVO carry out to enable the communities to better meet their basic needs and increase their ability to sustain effective child survival project activities?

E4. How did communities participate in the design, implementation and/or evaluation of child survival activities?

E6. What are the most significant issues currently being addressed by these health committees?

E7. What resources has the community contributed that will encourage continuation of project activities after donor funding ends?

E8. What are the reasons for the success or failure of the committees to contribute resources for continuation of effective project activities?

Interview of the Nurses Assigned to the Health Centers

I. SUMMARY OF PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

A2. Describe any circumstances which may have aided or hindered the project in meeting these objectives, and explain any unintended benefits of project activities.

II. PROJECT SUSTAINABILITY

A. Sustainability Status

A3. How have major project responsibilities and control been phased over to local institutions? If this has not been done, what are the plan and schedule?

B. Estimated Recurrent Costs and Projected Revenues

B6. Identify costs which are not likely to be sustainable.

E. Community Participation

E3. What activities did the PVO carry out to enable the communities to better meet their basic needs and increase their ability to sustain effective child survival project activities?

E6. What are the most significant issues currently being addressed by these health committees?

E7. What resources has the community contributed that will encourage continuation of project activities after donor funding ends?

E8. What are the reasons for the success or failure of the committees to contribute resources for continuation of effective project activities?

F. Ability and Willingness of Counterpart Institutions to Sustain Activities

F2. What linkages exist between the child survival project and the activities of key health development agencies (local/municipal/district/provincial/ state level)?

Nurses Assigned to Health Centers (2)

F3. What are the key local institutions the PVO expects to take part in sustaining project activities?

F4. Which child survival project activities do MOH personnel and other staff in key local institutions perceive as being effective?

F5. What did the PVO do to build skills of local MOH personnel or staff of key counterpart NGOs? did they teach them to train CHWs or manage child survival activities once AID funding terminates?

F6. What is the current ability of the MOH of other relevant local institutions to provide the necessary financial, human, and material resources to sustain effective project activities once CS funding ends?

Interview of Nursing Supervisors

I. SUMMARY OF PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

A2. Describe any circumstances which may have aided or hindered the project in meeting these objectives, and explain any unintended benefits of project activities.

II. PROJECT SUSTAINABILITY

A. Sustainability Status

A3. How have major project responsibilities and control been phased over to local institutions? If this has not been done, what are the plan and schedule?

D. Monitoring and Evaluation of Sustainability

D3. What qualitative data does the PVO have indicating a change in the sustainability potential of project benefits?

E. Community Participation

E3. What activities did the PVO carry out to enable the communities to better meet their basic needs and increase their ability to sustain effective child survival project activities?

E7. What resources has the community contributed that will encourage continuation of project activities after donor funding ends?

E8. What are the reasons for the success or failure of the committees to contribute resources for continuation of effective project activities?

F. Ability and Willingness of Counterpart Institutions to Sustain Activities

F2. What linkages exist between the child survival project and the activities of key health development agencies (local/municipal/district/provincial/ state level)?

Nursing Supervisors (2)

F3. What are the key local institutions the PVO expects to take part in sustaining project activities?

F4. Which child survival project activities do MOH personnel and other staff in key local institutions perceive as being effective?

F5. What did the PVO do to build skills of local MOH personnel or staff of key counterpart NGOs? did they teach them to train CHWs or manage child survival activities once AID funding terminates?

F6. What is the current ability of the MOH of other relevant local institutions to provide the necessary financial, human, and material resources to sustain effective project activities once CS funding ends?

Interview of Area Chiefs

II. PROJECT SUSTAINABILITY

A. Sustainability Status

A3. How have major project responsibilities and control been phased over to local institutions? If this has not been done, what are the plan and schedule?

B. Estimated Recurrent Costs and Projected Revenues

B2. What expenditures will continue to be needed (i.e. recurrent costs) if these key child survival activities are to continue for at least three years after child survival funding ends?

B3. What is the total amount of money in US dollars the project calculates will be needed each year to sustain the minimum of project benefits for three years after CS funding ends?

B6. Identify costs which are not likely to be sustainable.

D. Monitoring and Evaluation of Sustainability

D3. What qualitative data does the PVO have indicating a change in the sustainability potential of project benefits?

E. Community Participation

E3. What activities did the PVO carry out to enable the communities to better meet their basic needs and increase their ability to sustain effective child survival project activities?

E5. What is the number of functioning health committees in the project area? How often has each met during the past six months? Please comment on whether committee members seem representative of their communities.

E7. What resources has the community contributed that will encourage continuation of project activities after donor funding ends?

Area Chiefs (2)

F. Ability and Willingness of Counterpart Institutions to Sustain Activities

F2. What linkages exist between the child survival project and the activities of key health development agencies (local/municipal/district/provincial/ state level)?

F3. What are the key local institutions the PVO expects to take part in sustaining project activities?

F4. Which child survival project activities do MOH personnel and other staff in key local institutions perceive as being effective?

F5. What did the PVO do to build skills of local MOH personnel or staff of key counterpart NGOs? did they teach them to train CHWs or manage child survival activities once AID funding terminates?

F6. What is the current ability of the MOH of other relevant local institutions to provide the necessary financial, human, and material resources to sustain effective project activities once CS funding ends?

L. What is your plan for incorporating teachers in the health program?

Interview of the Teachers

II. PROJECT SUSTAINABILITY

E. Community Participation

E2. Which child survival activities do community members and leaders perceive as being effective at meeting current health needs?

F. Ability and Willingness of Counterpart Institutions to Sustain Activities

F4. Which child survival project activities do MOH personnel and other staff in key local institutions perceive as being effective?

F5. What did the PVO do to build skills of local MOH personnel or staff of key counterpart NGOs? did they teach them to train CHWs or manage child survival activities once AID funding terminates?

F6. What is the current ability of the MOH of other relevant local institutions to provide the necessary financial, human, and material resources to sustain effective project activities once CS funding ends?

Interview of Finance/Administration Department

II. PROJECT SUSTAINABILITY

B. Estimated Recurrent Costs and Projected Revenues

B2. What expenditures will continue to be needed (i.e. recurrent costs) if these key child survival activities are to continue for at least three years after child survival funding ends?

B3. What is the total amount of money in US dollars the project calculates will be needed each year to sustain the minimum of project benefits for three years after CS funding ends?

B4. Are these costs reasonable given the environment in which the project operates? (e.g. local capacity to absorb cost per beneficiary)

B7. Are there any lessons to be learned from this projection of costs and revenues that might be applicable to other child survival projects, or to AID's support of those projects?

G. Project Expenditures

G1. Attach a pipeline analysis of the project's expenditures.

G2. Compare the budget for planned expenditures identified in the DIP with the actual expenditures at the end of the project. Were some categories of expenditures much higher or lower than originally planned?

G3. Did the project handle the finances in a competent manner?

G4. Are there any lessons to be learned regarding project expenditures that might be helpful to other PVO projects, or relevant to AID's support strategy?

H. Attempts to Increase Efficiency

H1. What strategies did the PVO implement to reduce costs, increase productivity, or make the project more efficient?

H2. What are the reasons for the success or failure of the attempts to reduce costs, increase productivity or efficiency of this project?

Finance/Administration Department (2)

H3. Are there any lessons to be learned regarding attempts to increase efficiency that might be applicable to other PVO child survival projects or to AID's support of these projects?

J. Household Income Generation

J1. Did the project implement any household income-generating activities?

J2. Estimate the dollar amount added to a family or household's annual income, as a result of the income-generating activity of the project.

J3. Did the revenues contribute to meeting the cost of health activities? What percentage of project costs did income generation cover?

J4. Are there any lessons to be learned regarding household income generation that might be applicable to other PVO child survival projects or to AID's support strategy?

L. What impact in the community has the project had in the schools?

Interview of Other Private Organizations

II. PROJECT SUSTAINABILITY

E. Community Participation

E7. What resources has the community contributed that will encourage continuation of project activities after donor funding ends?

F. Ability and Willingness of Counterpart Institutions to Sustain Activities

F2. What linkages exist between the child survival project and the activities of key health development agencies (local/municipal/district/provincial/ state level)?

F3. What are the key local institutions the PVO expects to take part in sustaining project activities?

F4. Which child survival project activities do MOH personnel and other staff in key local institutions perceive as being effective?

Questions for Group Discussion

I. SUMMARY OF PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

B. Lessons Learned

B1. Outline the main lessons learned regarding the total project that are applicable to other PVO CS projects, and/or relevant to A.I.D.'s support of these projects.

II. PROJECT SUSTAINABILITY

K. Summary of Sustainability

K1. Please give a brief (nomore than one page), succinct summary of the responses to the previous questions concerning:

- the project's accomplishments (in terms of outputs and/or outcomes) in enabling communties to meet their basic health needs, and in promoting sustainability of effective child survival activities;
- the project's competence in carrying out its sustainability promoting activities;
- any lessons to be learned regarding sustainability that might be applicable to other PVO child survival projects, and/or relevant to AIDs support of these projects.

Appendix F: Evaluation Schedule

Sunday, July 3

The external evaluator and WRC headquarters staff person arrived

Monday, July 4

Initial meeting with evaluation team
Extracted data on indicators from surveys and other reports
Identified relevant documents
Began preparing guides for interviews
Discussed schedule and plan for field visits

Tuesday, July 5

Team members discussed and compared indicator data collected for goals and objectives in the baseline survey, two KPC surveys, and the health information system maintained by health guardians.
Guides for interviews were prepared by all team members in accordance with the 1993 Final Evaluation Guidelines for CS-VI Projects provided by A.I.D., Office of Private and Voluntary Cooperation.

Wednesday, July 6

Field interviews were initiated.
Group A conducted interviews of health supervisors in Talanga Health Center; nurses and auxiliary nurses in Orica Health Center; guardians, promoters, mothers, and one father in Orica; and a guardian in San Cristobal.
Group B interviewed a nurse in San Ignacio Health Center, a health promoter, health guardians (block representatives), mothers, and one father, also in San Ignacio.

Thursday, July 7

Group A interviewed auxiliary nurses, health committee members, mothers, teachers, promoters, a husband of a guardian, and one doctor in Guayape.
Group B interviewed teachers in San Ignacio and Escano de Tepale. Also interviewed was a health guardian, mothers, and members of a health committee in Escano de Tepale.

Friday, July 8

Groups A and B conducted interviews in Catacamas. Group A interviewed a nurse supervisor, auxiliary nurses, teachers, members of a health committee, guardians, mothers, and the Director of El Buen Pastor. Group B interviewed an auxiliary nurse in Rio Tinto, an auxiliary nurse in Siguate, guardians in Campo Nuevo, Casas Viejas, and Siguate, health committee members in Casas Viejas, and members of a community bank in Corralites.

Saturday, July 9

Guardians were interviewed in the Area 2 Office in Catacamas. Additional interviews were conducted of members of community banks in Catacamas by both teams in the late afternoon. Most of the day was spent reviewing and discussing interview findings. Summaries were developed on flipcharts.

Sunday, July 10

Promoters were interviewed in the Area 2 Office in Catacamas. The remainder of the day was spent reviewing and discussing interview findings. Summaries were developed on flipcharts.

Monday, July 11

On the return to Tegucigalpa, interviewed were conducted by Groups A and B at Sanitary Region No. 7 in Juticalpa and at ASHONPLAFA, also in Juticalpa. Group A interviewed the Region 7 minister and the Executive Director of ASHONPLAFA and Group B interviewed the MSP Area Chief, nurses, and the ASHONPLAFA Region 7 promoter.

Tuesday, July 12

Information from interviews conducted on July 11 was added to transcriptions of interview findings summarized on flipcharts in Catacamas. Team members worked individually on the content of the evaluation report.

Wednesday, July 13

Team members continued to work on the content of the evaluation report. The team met in the afternoon to discuss and agree upon lessons learned for the project.

Thursday, July 14

Team members continued to work on sections of the evaluation report, and additional discussions were held to discuss survey findings for each indicator.

Friday, July 15

Team members continued to work on sections of the evaluation report. Translation of the report began. Recommendations were shared with A.I.D./Honduras.

Saturday, July 16

The team leader worked jointly with the translator to finalize the first draft of the report in both English and Spanish.

Appendix G: Facilitators and Constraints

Growth Monitoring and Nutrition

A. Facilitators:

1. Support to mothers, schools, MOH, CHCs, and conscience of the community.
2. Demonstrations on how to prepare the food.
3. Follow-up visits to the mothers.
4. Giving Vitamin A during weighing sessions.
5. Use of mothers' experience for exclusive breastfeeding during the first 4 months.

B. Obstacles:

1. Some mothers lack money to buy food and thus do not want to know if their child is malnourished.
2. In the beginning, mothers didn't understand the need to weigh their children.
3. Rain.
4. Migration.
5. Lost growth charts.
6. A sister, rather than the mother, bringing a child to a session.
7. Exclusive breastfeeding is more difficult when mothers work.
8. The belief that breastmilk is not sufficient is an obstable to exclusive breastfeeding.
9. Does not know how to care for her nipples.

Control of Diarrhea

A. Facilitators:

1. MSP giving ORS packets (Litrosol) to the guardians.
2. Demonstrations on how to prepare the ORS (Litrosol).
3. Use of case histories and the experience of mothers within the community.

B. Obstacles:

1. Children do not like ORS (Litrosol).
2. Litrosol does not stop diarrhea.
3. Bad hygiene.
4. Self medication.

ARI

A. Facilitators:

1. Training WRH has given to the nurses. (Now they are giving the same messages to the community.)
2. Training at all levels.
3. Referrals and counterreferrals.
4. Use of focus groups to learn the thoughts of the community.
5. Training on Vitamin A and EPI for the prevention and training on signs and signals of pneumonia.
6. Community health committees sometimes pay for the medicine when there is none at the health center.

B. Obstacles:

1. In the beginning, the nurses gave inconsistent messages to the community.

2. Use of oils.

3. Insufficient supplies of antibiotics in the health centers.

Birth Spacing and Prenatal Care

A. Facilitators:

1. Coordination with ASHONPLAFA.

2. Use of high risk in the training.

3. Use of the good experiences of mothers who use contraceptives.

B. Obstacles:

1. Some grandmothers do not believe prenatal care is necessary.

2. Some husbands believe that if a wife uses contraceptives, she will be unfaithful with another man.

3. The Catholic Church (and Pastoral Social) and some evangelical churches.

4. Some mothers believe that contraceptives or tubal ligation will harm them or cause them to become sick.

Appendix H: Midterm Evaluation Recommendations for Sustainability

IV. Main Recommendations

To ensure that the objectives, goals and sustainability of the project are achieved:

1. Ensure that all participation revolves around Growth Monitoring and generates an integrated community response, based on a formal community structure that has direct relations with the MOH and on which the health guardian depends. Such participation must be based on the current aid and supervision structure and the same activities carried out by the project, focused on risk groups. Participation in actions currently under implementation should be included, i.e. a Change of Eating Habits, Control of Diarrhoea and Pneumonia, and the supply of Vitamin A and Vaccinations.

   Volunteers should play a specific role in such services as growth control and ORUs. The objective of this strategy is to reduce the present workload of volunteers, sharing it with other members of the community and generating support networks for different sectors of the population in need of preventive services and adequate information.

CS Support Networks:

Vaccinations: Under the responsibility of an individual who is interested in vaccinating his/her own children as well as the other children in the neighbourhood or community. This person must be trained to: 1) identify newborn babies and provide a vaccination card for them; 2) pinpoint the children who require vaccinations each month; 3) make sure the children are vaccinated; and 4) once they have been fully vaccinated, remove their names from the list at 11 months.

Diarrhoea Control: A mother who has gone through the experience of rehydrating her child, needs additional training in oral rehydration and the dietary management of diarrhoea. She should: 1) Set up a table in a corner of her home for preparing ORS; 2) put up a notice offering ORT for REHYDRATION; 3) stock ORS; 4) make time to encourage mothers to resort to ORS and teach them how to use them.

Activities that unite guardians/mothers/promoters should be encouraged, so that they may all strive towards the same goal and project an overall view of the project's intentions. This could be achieved through local planning meetings with specific goals. The promoters should **PAVE THE WAY** to this end.

To increase the applicability, competence and quality of the project, the following is required:

3. A joint MOH/WRH/Community design of a reference/counter-reference system for each individual community within the scope of the project.

4. A review of the supervision instruments at all levels:

- Strenthen and ensure a joint WRH/MOH supervision at all levels.
- Ensure a promoter>community supervision process that uses the data system.
- Monitor the joint WRH/MOH implementation of Child Survival activities at a management and coordination level in selected communities.
- Produce joint supervision reports for distribution to all WRH and MOH establishments.

5. Review the Data System, as follows:

- Ensure that the data collected is concentrated in CESAR (Health Post), from where the promoter and the nurse may obtain the information they require for their reports on communities and volunteers.

- Review the data handling process at a community level (data collection/data use), placing

more emphasis on MOH coordination, production, and monitoring.

- Help the population to objectively appreciate the project's achievements in the different communities. Simple, adequate systems should be used for feeding back the information to the community. Specific goals must be monitored as well as all-embracing activities.
- Systematically share periodic achievements by areas (News Bulletin), using information that proves the benefits of the project and the MOH's achievements, in terms of coverage, reduced MOH expenditure and community involvement in the MOH's objectives.
- Promote the exchange of information on recommendations and experiences obtained from other local and international PDOs.

6. Technical aspects of the participation:

- Review and reduce risk population criteria for each participation. Concentrate efforts on the risk of ill-health.
- Review the growth control component of the food counselling program, concentrating its implementation on the high-risk population, carrying out pilot experiences involving individual eating practices.
- Review the treatment of diarrhoea, introducing dietary management practices. Limit the use of ORS to cases of dehydration, as recommended by local regulations. Strengthen the MOH's initiative to set up Community Oral Rehydration Units (ORUs) in each community, once the WRH and MOH staff have been duly trained.
- As regards mothers' health, particularly during pregnancy, concentrate on high risk groups, ensuring their access to a Family Planning centre within their community which should be linked (reference/counter-reference) to CESAMO or another medical centre. The initial medical care of a woman or a couple should include a medical consultation. Study self-financing alternatives for these community services, i.e. locally controlled Community Medical Centres for Women and Couples.
- With respect to Pneumonia, study different alternatives for identifying and managing cases in each community. In coordination with the MOH, implement a community case-management policy.

7. Coordinate the development of three joint training courses for WRH and MOH staff with PAHO/Washington D.C. and Tegucigalpa, within the next six months: Supervisory Skills for Diarrhoea Control; Supervisory Skills for ARI; and Basic Principles of Epidemiological Disease Control.

8. Make joint efforts (WRH/MOH/USAID-Honduras) to carry out operational research work on:

- The project's estimated recurrent expenses and the population's expenses on health

services in each community.

- Mechanisms for recording the impact of community banks on family health.
- The recovery of expenses through drug stores, community family planning services and others, managed by formal community structures.
- The allocation of the MOH's budget items for providing health care to support the communities under the project's sphere of influence.
- Review the existing education materials, using suitable messages for users.

9. Ensure coordination between WRC and USAID/DC, to identify possible technical assistance for the Health Information System and Nutrition.

10. In the budget and from foreign sources, identify funds for implementing a technical assistance program in the short and medium terms, to provide the necessary technical assistance. The program should include:

- Technical Assistance for training MOH and WRH staff. PAHO's contribution of training materials for the supervision and epidemiology courses could be included.
- Operational Research. It is possible to carry out research work to improve the program. The local USAID mission and the MOH have regional resources available through the Health Sector II program, for operational research work that could be used with the MOH establishments.

Appendix I: 1994 30-Cluster Knowledge, Practice, and Coverage (KPC) Survey Results

EXECUTIVE SUMMARY

The Study on Knowledge, Practice and Coverage (KPC) was carried out in 8 municipalities of two Departments of Honduras, Francisco Morazán and Olancho, from June 2 to 16, 1994. This task was executed by World Relief Honduras staff with the technical assistance of World Relief Corporation.

The purpose of the study is to obtain information on child survival knowledge and practice of mothers of children under 2 years of age, and to obtain the standard indicators needed to evaluate the final accomplishments of the Child Survival Project - Guayape (CSP-G).

The study followed the World Health Organization (WHO) model of "30 Clusters". The questionnaire which was used was adapted from the generic questionnaire designed by the PVO Child Survival Support Office (PVO CSSP) of the Johns Hopkins University, which was refined by the Child Survival Project - Guayape (CSP-G) field personnel.

The objectives of the study were accomplished in two weeks. The team that went to the field discussed the results in order to assess the accomplishments of the Project.

The more outstanding results include: 98% of the children have been breastfed; 67% initiated their breastfeeding within the first 8 hours after birth; 55% received exclusive breastfeeding in the first 4 months; 86% received complementary food between 5 and 9 months of age, and 55% continued being breastfed between 20 and 24 months of age. Sixty-one percent (61%) of the children have had access to the growth monitoring program, and 62% of those with cards attended in the last 4 months. The prevalence of children who had diarrhea in the last two weeks was 33%, during which 86% of the mothers continued breastfeeding their child, 65% continued giving them an equal or greater amount of liquids, 66% continued giving them an equal or greater amount of food and 44% used Oral Rehydration Therapy (ORT). The prevalence of Acute Low Respiratory Infections (ALRI) was 31% in the last two weeks. Fifty-four percent (54%) of these sought medical treatment at a health center or clinic. Eighty-eight (88%) of the children between 12 and 24 months of age have a complete immunization card, with a 1.5% drop-out rate. Seventy-three percent (73%) of the mothers have had at least two doses of tetanus toxoid; 32% of the women who do not desire or are not sure of having children in the next two years were using modern methods of family planning; 80% of the mothers went for prenatal care.

NOTE: For more detail see the Final Evaluation KPC Survey enclosed with this evaluation.